Vaccination Questionnaire

Date / /

Name **Hospital ID**

Date of birth / / (Day / Month / Year) **Body Temperature** ℃

【Questions】

1	Do you have any concerns about your health today?	Yes ・ No
2	Do you currently have any sickness?	Yes ・ No
	(Name of disease:)	
3	Do you currently take any medications?	Yes ・ No
	(Name of medicine:)	
4	Have you ever had convulsions?	Yes ・ No
	If yes, when did you have it? ( )	
5	Have you been diagnosed with immunodeficiency?	Yes ・ No
6	Have you ever had an allergic reaction after receiving medicine or eating a particular food?	Yes ・ No
7	Have you ever had any allergic reaction after eating eggs?	Yes ・ No
8	Have you received immunizations within 4 weeks?	Yes ・ No
	(When:) (Name of vaccine:)	
9	Have you ever had any major illness in the past?	Yes ・ No
	(Name of disease:)	
10	Have you ever felt sick after receiving immunizations?	Yes ・ No
	If yes, please describe the specific name vaccines and symptoms. ( )	
11	Have you ever felt sick with blood sampling or dental treatment?	Yes ・ No
12	【Women only】Is there a possibility you are pregnant?	Yes ・ No
13	Do you have any concerns about your current health condition?	Yes ・ No
14	Are you a student? (We offer student discount prices for some vaccinations)	Yes ・ No
	(Name of school:)	
	Please present your student card to your doctor.	

【Physician's notes】 以上の問診と診察の結果、本日のワクチンの接種は　可　・　不可

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