National Immunization Survey – Teen

Teen Immunization History Questionnaire

Confidential Information. If received in error, please call 1-800-860-1178.

CDC
SAFER·HEALTHIER·PEOPLE™

START HERE → **Please review your records and complete this questionnaire for the adolescent identified on the label to the right. Complete pages 1 and 3 only. Return the questionnaire in the postage-paid envelope or fax toll-free to (800) 860-2291. This information is confidential, if faxing, please take extra care to dial the correct number.**

1. Which of the following best describes your immunization records for this adolescent?

- ☐ You have all or partial immunization records for this adolescent for vaccines given by your practice or other practices.
  - → Was any of the immunization information for this adolescent obtained from your community or state registry? ☐ Yes ☐ No ☐ Don't Know
  - Go to question 2 below.
- ☐ Other-Explain _____
- ☐ You have provided care to this adolescent, but do not have immunization records.
- ☐ You have no record of providing care to this adolescent.

Please complete item 9 and return form as instructed above.

2. According to your records, what is this adolescent's date of birth?

Month ____ Day ____ Year ____ ☐ Don't know

3. What was the date of this adolescent's *first* visit, for any reason, to this place of practice?

Month ____ Day ____ Year ____ ☐ Don't know

4. Did this adolescent receive an 11-12 year old well child exam or check-up?

☐ Yes ☐ No ☐ Don't know

5. About how many physicians work at this practice, including those who work part-time?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4-6 ☐ 7-10 ☐ 11 or more

6. Which of the following best describes this facility?

Check only one box, representing the most specific description.

- ☐ Federally-qualified health center including community/migrant/rural/Indian health center.
- ☐ Hospital-based clinic, including university clinic, or residency teaching practice.
- ☐ Private practice, including solo, group practice, of HMO.
- ☐ Public health department-operated clinic
- ☐ STD clinic/School clinic/Teen clinic
- ☐ Other-Explain _____

→ **Which of the following best describe the main specialties of this facility?**

Check all that apply.

☐ Pediatrics ☐ Family Practice ☐ General Practice
☐ Internal Medicine ☐ OB/GYN
☐ Other-Explain _____

7. Does your practice order vaccines from your state or local health department to administer to children?

☐ Yes ☐ No ☐ Don't know

8. Did you or your facility report any of this adolescent's immunizations to your community or state registry?

☐ Yes ☐ No ☐ Don't know
☐ Not applicable (No registry in my community/state)

9. Contact information for the person returning this form.

Name: _____

☐ Physician ☐ Nurse
☐ Office Manager/ Receptionist ☐ Medical Records Administrator/Technician
☐ Other

Phone: ( ) _____ _____ ext. _____
Fax: ( ) _____ _____ ext. _____

10. Go to next page →

Please review the instructions and examples below. Then complete the "Shot Grid" on the next page.

Refer to your vaccination records for the adolescent named on the labels on the front cover and next page of this form.

- **Record the month, day and year that each type of shot was given.**

EXAMPLE

Vaccine		Date Given Month	Day	Year	Given by other practice?		Type of Vaccine
Tetanus boosters	1	11	18	2002	☐ Yes	☐ No	
MMR	1	9	20	2002	☒ Yes	☐ No	
	2				☐ Yes	☐ No	

- **Be sure to mark the "Yes" box under "Given by other practice?" for vaccinations given by another practice (see example above).**
- **Use the "Other" space to enter any vaccines not listed on the next page or any additional doses of listed vaccines that were given to this adolescent (see example below)**

Other	1	11	20	2001	☐ Yes	☐ No	Please do not record Polio, Hib, or Pneumococcal conjugate vaccine (Prevnar) given before 5 years old	*Please enter a description of each vaccine dose* TYPHOID
	2				☐ Yes	☐ No		

- **After completing the "Shot Grid" on the next page, please return this form in the envelope provided.**

  (Optional) You may also attach a copy of your immunization history records for this adolescent to this form and send it back to the National Opinion Research Center, National Immunization Survey – Teen, 1 N State St FL 16, Chicago, IL 60602.

  Or you may fax the confidential information to (800) 860-2291. If faxing this form, cut along fold to separate pages, then fax pages 1 and 3. Do not fax this page.

National Immunization Survey – Teen

Please record all vaccination dates in your records for these vaccine types. We realize you might not have the full immunization history of this adolescent.

Vaccine	Date Given (Month / Day / Year)	Given by other practice?	Type of Vaccine
Td/Tdap boosters received after age 6	1 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	*Mark one box for each vaccine dose received after age 6* ☐ Td ☐ Tdap
	2 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	☐ Td ☐ Tdap
	3 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	☐ Td ☐ Tdap
Hepatitis B received since birth	1 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	**HepB only** ☐ 0.5 ml Recombivax ☐ 1.0 ml Recombivax ☐ Engerix ☐ HepB only - unknown type ☐ HepB-Hib
	2 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	☐ 0.5 ml Recombivax ☐ 1.0 ml Recombiva ☐ Engerix ☐ HepB only - unknown type ☐ HepB-Hib
	3 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	☐ 0.5 ml Recombivax ☐ 1.0 ml Recombiva ☐ Engerix ☐ HepB only - unknown type ☐ HepB-Hib
	4 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	☐ 0.5 ml Recombivax ☐ 1.0 ml Recombivax ☐ Engerix ☐ HepB only - unknown type ☐ HepB-Hib
Influenza received in the past three years	1 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	**Injected flu vaccines** ☐ Fluzone ☐ Fluvirin ☐ Fluarix ☐ Flulaval **Inhaled nasal flu spray** ☐ Flumist
	2 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	☐ Fluzone ☐ Fluvirin ☐ Fluarix ☐ Flulaval ☐ Flumist
	3 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	☐ Fluzone ☐ Fluvirin ☐ Fluarix ☐ Flulaval ☐ Flumist
MMR	1 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	☐ MMR ☐ MMR-Varicella ☐ Measles only
	2 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	☐ MMR ☐ MMR-Varicella ☐ Measles only
Varicella	1 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	☐ Varicella only ☐ MMR-Varicella
	2 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	☐ Varicella only ☐ MMR-Varicella
☐ *Child has a history of chickenpox*			
Hepatitis A	1 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	☐ HepA only (Havrix or Vaqta)
	2 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	☐ HepA only (Havrix or Vaqta)
	3 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	☐ HepA only (Havrix or Vaqta)
Pneumococcal polysaccharide	1 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	
	2 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	
Meningococcal	1 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	☐ MCV4 (Menactra) ☐ MPSV4 (Menomune)
	2 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	☐ MCV4 (Menactra) ☐ MPSV4 (Menomune)
Human papillomavirus (HPV)	1 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	
	2 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	
	3 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	
Other	1 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	*Please enter a description of each vaccine dose*
	2 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	
	3 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	
	4 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	
	5 ☐☐ ☐☐ ☐☐☐☐	☐ Yes ☐ No	

Please do not record Polio, Hib, or Pneumococcal conjugate vaccine (Prevnar) given before 5 years old

Please remember to answer all questions on page 1

If you need more space to report vaccines, please attach additional sheets.

Thank you!

Centers for Disease Control and Prevention

U.S. Department of Health and Human Services

Thank you for your help with this important study!

If you would like more information about the National Center for Immunization and Respiratory Diseases, including information about vaccine recommendations or data and statistics from previous years of the National Immunization Survey, please visit the National Immunization Survey website at www.cdc.gov/vaccines.

If you would like more information about the National Immunization Survey, please visit the National Immunization Survey website at www.cdc.gov/nis. If you have any questions or comments about this study, please call (800) 860-1178 or email nis@cdc.gov.

Note: Do NOT send any confidential patient information, such as patient's name or date of birth, in an email message.