CHRONOLOGICAL RECORD OF MEDICAL CARE

Smallpox Vaccination Clinical/Routine Follow up Note

1. Today's Date (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

2. Smallpox Vaccination Date ☐☐/☐☐/☐☐☐☐

3. Did you put a bandage on the vaccination site ○ Yes ○ No

3a. IF YES: How many days did you use a bandage? ☐☐

3b. Did you see the vaccination site every day or two? ○ Yes ○ No

4a. Vaccination site appearance today (Check all that apply)

- ☐ local redness
- ☐ bump
- ☐ reddish blister
- ☐ whitish blister
- ☐ scab or crust
- ☐ local itching
- ☐ local rash
- ☐ nothing

4b. Vaccinee recall of appearance since vaccination (Check all that apply)

- ☐ local redness
- ☐ bump
- ☐ reddish blister
- ☐ whitish blister
- ☐ scab or crust
- ☐ local itching
- ☐ local rash
- ☐ nothing seen
- ☐ patient did not remember/observe

4c. Check anything else experienced after the smallpox vaccination (Check all that apply)

- ☐ headache
- ☐ body rash
- ☐ itchy all over
- ☐ eye infection
- ☐ fever (temp in box)
- ☐ muscle aches
- ☐ feeling lousy
- ☐ swollen lymph nodes
- ☐ bandage reaction
- ☐ chest pain
- ☐ shortness of breath
- ☐ other (describe in box)

5. Any problems following vaccination? (Check all they apply)

- ☐ Restricted activity — How many days? ☐☐
- ☐ Limited duty — How many days? ☐☐
- ☐ Missed work — How many days? ☐☐
- ☐ Took medication (list in box) — How many days? ☐☐
- ☐ Visited clinic or emergency room
- ☐ Hospitalized
- ☐ Other (described in box)

6. Note any other reactions, problems or medications following vaccination:

7. Does the patient believe anyone might have become ill as a result of the vaccination? ○ Yes ○ No ○ Unsure
If YES or UNSURE describe in box (or on continuation page)

8. Provider evaluation and action (check all that apply:

- ☐ Fully Immunized ("major reaction, "take")
- ☐ Equivocal response
- ☐ Referred to Vaccine Healthcare Centers
- ☐ Re-vaccination indicated
- ☐ Follow-up for events described
- ☐ Medication prescribed (list)
- ☐ No further follow up planned
- ☐ Consultation Allergy/Immunology/Dermatology/Cardiology/other_____)
- ☐ Other action (describe in box) Report to VAERS if warranted.

Provider Notes:

Provider Signature and Printed Name/Stamp:

Last Name

First Name MI

Social Security Number

Patient's identification (May use mechanical imprint)

RECORDS MAINTAINED AT:
RANK/GRADE
SEX
DATE OF BIRTH
SPONSOR NAME
(or Sponsor SSN)
RELATIONSHIP TO SPONSOR
(Or FMP)
ORGANIZATION
STATUS
DEPT/SVC