CHRONOLOGICAL RECORD OF MEDICAL CARE

Smallpox Vaccination Initial Note Page 1 of 2

This page may be completed by potential vaccine recipient

Shade Circles Like This--> ●
Not Like This--> ⊗ ✓

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

2a. GENDER ○ Male ○ Female 2b. First day of last normal menstrual period:___/___/___/

2c. FEMALES: Was your last menstrual period normal and on time? ○ Yes ○ No ○ Unsure

2d. Are you currently breastfeeding? ○ Yes ○ No

3. Could someone you LIVE WITH or YOU be pregnant? ○ Yes ○ No ○ Unsure

4. Did you ever receive smallpox vaccine? ○ Yes ○ No ○ Unsure

4a. IF YES: Were you vaccinated within the last 10 years? ○ Yes ○ No ○ Unsure

4b. IF UNSURE: Birth Year ☐☐☐☐ First Year in Military (if applicable) ☐☐☐☐

5. Have you ever had a serious problem after smallpox or other vaccination? (Describe below) ○ Yes ○ No ○ Unsure

6. Do you currently have an illness with fever? ○ Yes ○ No ○ Unsure

7. Are you allergic to any of these products: polymyxin B, neomycin? ○ Yes ○ No ○ Unsure

Before vaccinating against smallpox, we want to know if you or your household close contacts have any of several medical conditions.

Please answer the following questions to the best of your knowledge.	**Myself**	**Close Contact**
8. Do you OR someone you currently live with NOW HAVE any of the following skin problems: Psoriasis (scaly skin rash), Burns (other than mild sunburn), Impetigo (skin infection), Uncontrolled Acne, Shingles (herpes zoster), Chickenpox, Darier's disease or Other skin conditions (describe below)?	○ Yes ○ No ○ Unsure	○ Yes ○ No ○ Unsure
9. Do you OR someone you currently live with NOW HAVE or RECENTLY HAD a problem or take(s) medication that affects the immune system? For example: have or take medication for HIV, AIDS, leukemia, lymphoma, or chronic liver problem; have or take medication for Crohn's disease, lupus, arthritis, or other immune disease; have had radiation or X-ray treatment (not routine X-rays) within the last 3 months; have EVER had a bone-marrow or organ transplant (or take medication for that); or have another problem that requires steroids, prednisone or a cancer drug for treatment.	○ Yes ○ No ○ Unsure	○ Yes ○ No ○ Unsure
10. Have you OR someone you currently live with EVER HAD Eczema or Atopic Dermatitis? (Usually this skin condition involves an itchy, red, scaly rash that lasts more than 2 weeks. It often comes and goes.) IF YES or UNSURE: for either you or your close contact, Answer 10a-10e	○ Yes ○ No ○ Unsure	○ Yes ○ No ○ Unsure
10a. A doctor has made the diagnosis of eczema or atopic dermatitis.	○ Yes ○ No ○ Unsure	○ Yes ○ No ○ Unsure
10b. There have been itchy rashes that have lasted more than 2 weeks.	○ Yes ○ No ○ Unsure	○ Yes ○ No ○ Unsure
10c. At least once, there is a history of an itchy rash in the folds of the arms or legs.	○ Yes ○ No ○ Unsure	○ Yes ○ No ○ Unsure
10d. There is a history of eczema and food allergy during childhood.	○ Yes ○ No ○ Unsure	○ Yes ○ No ○ Unsure
10e. A doctor has made the diagnosis of asthma or hayfever (including first-degree relatives).	○ Yes ○ No ○ Unsure	○ Yes ○ No ○ Unsure

11. Are you being treated with steroid eye drops or ointment or have you had recent eye surgery? ○ Yes ○ No ○ Unsure

12. Do you have a heart or vessel condition, such as angina, earlier heart attack, coronary artery disease, congestive heart failure, cardiomyopathy, stroke, “mini stroke”, chest pain or trouble breathing on exertion? ○ Yes ○ No ○ Unsure

13. Check EACH of the following conditions that apply to you: ○ Heart Condition before age 50 in mother, father, brother, sister ○ Smoke cigarettes now ○ High blood pressure ○ High cholesterol ○ Diabetes or high blood sugar

14. Do you have a child in home less one year of age? ○ Yes ○ No

15. Do you have other questions or have other concerns you would like to discuss? ○ Yes ○ No

Explain "other," "unsure," or additional concerns (may use additional page). NOTE: If you might have a risk factor for HIV infection, we can arrange for HIV testing. FOR FEMALES: If you might be pregnant, or likely to become pregnant, please tell us. You may need additional pregnancy testing.

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

CHRONOLOGICAL RECORD OF MEDICAL CARE

Smallpox Vaccination Initial Note Page 2 of 2

This page may be completed by a healthcare provider

1. Provider Assessment Date (MM/DD/YYYY)

☐☐ / ☐☐ / ☐☐☐☐

If Provider Assessment Date or Action Taken Immunization Date is blank, Default is "Today's date" on page 1.

2. Reason for Vaccination (Indicate One):

- ○ Pre-outbreak: disease prevention
- ○ Post-outbreak: not exposed to virus
- ○ Post-outbreak: exposed to virus
- ○ Other reason (Describe)

3. Vaccine Risk Factors based on page 1 review and interview

(Check all that apply):	Self	Close Contact
No restriction	○	○
Pregnancy	○	○
Immune suppression	○	○
Skin condition	○	○
Relevant allergy	○	
Heart condition	○	3+ RF ○
Unsure	○	○ (Describe)

4. Provider comment on any concerns about contraindications, need to defer, need to consult, and/or relevant diagnosis

5. Provider Decision and Plan (Check all that apply):

- ☐ Vaccinate: Primary (e.g. birth year >1972, military entry >1984)
- ☐ Vaccinate: Revaccination
- ☐ Medically immune: vaccinated within approp interval (MI)
- ☐ Vaccination deferred: Pending consult or lab test
- ☐ Vaccination deferred: Temporary contraindication (MT)
- ☐ Vaccination contraindicated unless exposed (MP)
- ☐ Vaccination not given (other reason specify below):

6. IF NOT IMMUNIZED, Check all that apply:

- ☐ Reason for non-immunization explained
- ☐ Lab test requested
- ☐ Consult request written/sent
- ☐ Follow up appointment planned
- ☐ Other reason (specify below):

List labs or consults requested, and length of temp referrals

VACCINE ADMINISTRATION

Vaccination Date (M M / D D / Y Y Y Y)

☐☐ / ☐☐ / ☐☐☐☐

7. Vaccination Action Taken:

Location: ○ Left Arm ○ Right Arm ○ Other Location (Describe)

Number of jabs: ☐☐

Lot # ☐☐☐☐☐—☐☐☐☐ Mfr # ☐☐☐

For QA use: local vial serial # ☐☐☐

8. IF IMMUNIZED, Check all that apply

- ☐ Information sheet given to recipient
- ☐ Recipient advised about post-vaccination reaction and site care
- ☐ Reasons for follow-up clinic visit described
- ☐ Patient understands information given
- ☐ Bandages provided if needed.

Please assure that all actions taken and deferrals are updated into your service's electronic Immunization Tracking System (ITS) as soon as possible.

Provider Signature and Printed Name/Stamp:

Vaccine administered by: (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)
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