VACCINE ADVERSE EVENT REPORTING SYSTEM (VAERS)
Patient Identity Kept Confidential

Supplemental Information for Smallpox Vaccine in Pregnancy Registry

Return to NHRC-birthregistry@med.navy.mil or FAX 619-767-4806 DSN 577-4806
Telephone 619-553-9255 or DSN 553-9255. POC: Dr. A. Conlin

Other ways to report Vaccine Adverse Events: http://vaers.hhs.gov, 800-822-7967, PO Box 1100, Rockville, MD 20849-1100
Clinical consultation on vaccination issues may be referred to the Vaccine Healthcare Centers, www.vhcinfo.org , 301-319-2904

These data will be used to increase understanding of adverse events following vaccination and will become part of Centers for Disease Control and Prevention Privacy Act System 09-20-0136, "Epidemiologic Studies and Surveillance of Disease Problems." Information identifying the person who received the vaccine or that person's legal representative will not be made available to the public, but may be available to the vaccinee or legal representative.

Patient Name:
Patient SSN:
Patient date of birth:
Patient military rank and branch of service:
Patient military unit and location:
Patient email and/or phone:

Patient mailing address: _____
Street Address
_____
City, State, Zip Code

Form completed by:
Relation to patient:
Email and/or phone:
Date form completed:

Vaccine manufacturer (circle one): ◯ Wyeth/Dryvax® ◯ Acambis/ACAM2000™ ◯ Unknown
Lot number:

Date smallpox vaccination given:
Facility name/location:

Date smallpox vaccine "take" assessed:
Was "take" evident? ◯ Yes ◯ No

Was pre-vaccination screening form completed? ◯ Yes ◯ No ***[If Yes, please provide copy]***
Did patient express concern about pregnancy at screening visit? ◯ Yes ◯ No
Was pregnancy test done on day of vaccination? ◯ Yes ◯ No

Date pregnancy diagnosed:

Date of last normal menstrual period:

If ultrasound used for gestational age, provide results:

Method of birth control used at time of conception, if any:

Number of previous pregnancies:
List outcomes (with dates) of any previous pregnancies.

Was this the first smallpox vaccination for this patient? ◯ Yes ◯ No
If No, please provide approximate date(s) of any previous smallpox vaccinations.

Were any other vaccines administered during this pregnancy? ◯ Yes ◯ No
If Yes, please list other vaccines and dates administered:

Medical facility where patient will be followed (name/address/phone):