OwassoDrug
Your Neighborhood Pharmacy

PATIENT INTAKE FORM

Name:_____

Address:_____

City/State/Zip:_____

Phone #:_____

DOB:_____ Sex: M F Weight:_____

Allergies:_____ Medical Conditions:_____

Your primary Care Provider (and phone #, if known):_____

What Vaccines are you wanting?	☐ Flu	☐ Pneumonia	☐ Tdap	☐ Shingles	☐ Covid (Pfizer or Moderna)

The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

		Yes	No	Don't Know
1.	Are you sick today?	☐	☐	☐
2.	Do you have allergies to any vaccines?_____	☐	☐	☐
3.	Have you had any allergies to medications or food?_____	☐	☐	☐
4.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
5.	Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorders?	☐	☐	☐
6.	Do you have cancer, leukemia, AIDS or any other immune system problems?	☐	☐	☐
7.	Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☐	☐
8.	Have you had a seizure, brain or other nervous system problems?	☐	☐	☐
9.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10.	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
11.	Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
12.	Did you bring your immunization record card with you?	☐	☐	☐

Please read the following statements and sign below on the signature line.
I have read or have been explained the information about the vaccine that I am to receive. I have received and read a Vaccine Information Statement (VIS). I understand the benefits and risks of the vaccine being administered and authorize the administration of the vaccine to me. Furthermore, I release Owasso Drug and their employees from any claim arising out of or in any way related to this or these immunization(s).

I consent to the release of this information to my primary care physician as listed on the receipt of vaccination. I agree to wait in the vaccination location for approximately 15 minutes for observation after vaccination.

☐ **Medicare Patients**: I authorize Owasso Drug and Novitas to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize all records to act on this request. I request that payment of authorized benefits be made on my behalf to Novitas and Owasso Drug as my Medicare PartB provider.

X_____ Date:_____

Signature of person to receive vaccine or person authorized to make request (parent of guardian)

for office use only

Vaccine	Vaccine	Vaccine
Lot# / Exp.	Lot# / Exp.	Lot3 / Exp.
Mfr.	Mfr.	Mfr.
Date on VIS	Date on VIS	Date on VIS
Date given	Date given	Date given
Site	Site	Site

X_____ Date:_____

Signature of Administrator

Adapted from the Immunization Action Coalition Screening Questionnaire for Adult Immunization (04/09).