



SPRUCE MULTISPECIALTY GROUP

1275 East Spruce, Suite 101

Fresno, California 93720

(559) 439-5757

Simple Immunizations

Name _____
(If minor, name of parent/guardian) _____
Age _____
Primary Physician _____

Date of Birth: _____

Gender: M/F

Allergies to medications, vaccinations, foods or environmental factors

Current medical conditions (such as asthma, high blood pressure, etc.)

Current medications/hormones

Do you have any of the following conditions? (Please check yes or no, ADD OTHERS NOT LISTED)

	Y	N		Y	N		Y	N		Y	N
Pregnancy			HIV disease			Heart disease			Psychiatric disorders		
Dental disease			Over 60			Diabetes			Seizures/epilepsy		
Depression			Blood Conditions			Lung disease			Heart rhythm problems		
Cancer			Psoriasis						Long term steroid use		
Other:											

Are you planning on becoming pregnant in the next three months? Yes/no

Prior immunizations (with dates): Attach immunization card if available.

	Date		Date		Date
Diphtheria/tetanus/pertussis		Rabies		Plague	
Influenza		Immune globulin		Lyme's Disease	
Polio		Japanese encephalitis		BCG (TB)	
Hepatitis A		Typhoid oral			
Hepatitis B		Typhoid injection			
Measles		Yellow fever			
Mumps		Cholera			
Rubella		Menomune			
Pneumococcal		Menactra			

Patient Acknowledgement

I am satisfied that relevant VAERS informational handouts on the vaccines that I am receiving were given to me. My questions about the diseases and vaccines have been answered to my satisfaction. I believe I understand the benefits and risks of each vaccine I am to receive and authorize Fresno International Travel Medical Center (FITMC) staff to administer these vaccines. I know it is my responsibility to contact FITMC with any adverse reaction to vaccinations/prescriptions received from FITMC.

Signature of person to receive vaccine or parent or guardian:

Signature

Date

Documentation

Date	MA	Date	Provider	notes

