

# Pre-Vaccination Checklist for COVID-19 Vaccines



## For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.

**If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Patient Name \_\_\_\_\_

Age \_\_\_\_\_

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
<ul style="list-style-type: none"> <li>• If yes, which vaccine product?                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Pfizer</li> <li><input type="checkbox"/> Moderna</li> <li><input type="checkbox"/> Another product _____</li> </ul> </li> </ul>			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?			
<ul style="list-style-type: none"> <li>• Was the severe allergic reaction after receiving a COVID-19 vaccine?</li> <li>• Was the severe allergic reaction after receiving another vaccine or another injectable medication?</li> </ul>			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			

Form reviewed by \_\_\_\_\_

Date \_\_\_\_\_