Middlesex Health

COVID Pre-Vaccine Questionnaire

Patient First Name: _____ **Patient Last Name:** _____

Patient DOB: _____

I'm here for my (circle one): 1st Dose Appointment 2nd Dose Appointment

1.) Are you feeling sick today?
- ❑ Yes
- ❑ No

2.) Have you previously received a COVID-19 vaccine?
- ❑ Yes, I received the Pfizer-BioNTech COVID-19 Vaccine
- ❑ Yes, I received the Moderna COVID-19 Vaccine
- ❑ Yes, but I don't know which COVID-19 vaccine I received
- ❑ No

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?
- ❑ Yes
- ❑ No
- ❑ Don't know

4.) Have you had a severe allergic reaction (e.g., anaphylaxis) after receiving COVID-19 vaccine?
- ❑ Yes
- ❑ No
- ❑ I have not received a COVID-19 Vaccine

5.) Have you had a severe allergic reaction (e.g. anaphylaxis) to another vaccine or any other injectable medication?.
- ❑ Yes
- ❑ No

6.) Do you have a bleeding disorder or are you taking a blood thinner?
- ❏ Yes
- ❏ No

7.) Have you received passive antibody therapy (monoclonal antibodies, convalescent plasma) as treatment for COVID-19?
- ❏ Yes
- ❏ No
- ❏ Don't know

8.) Are you immunocompromised (have a weakened immune system such as cancer, leukemia, HIV/AIDS, or any other immune system problem) or are you taking medication that affects your immune system?
- ❏ Yes
- ❏ No

9.) Are you pregnant?
- ❏ Yes
- ❏ No
- ❏ Not sure
- ❏ Not applicable

10.) Are you breastfeeding (nursing)
- ❏ Yes
- ❏ No
- ❏ Not applicable

❏ I have received the EUA Fact sheets(s) for COVID-19 Vaccine(s). I acknowledge that I have received a copy of the Privacy Policy and Terms and Conditions.

Patient Signature_____ Date:_____

Rvsd: 01/05/2021