

# Immunization Health History

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Last First MI Last four digits

Work Phone: (\_\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Area Code

Are you exposed to Blood or Body Fluids on the Job?     Yes                       No

Service Line/Department: \_\_\_\_\_ Date of Employment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Job Title: \_\_\_\_\_

Chronic Disease/Illness: \_\_\_\_\_

Allergies: \_\_\_\_\_

Comments: \_\_\_\_\_

<b>Infectious Disease History</b>							
<i>(Please provide vaccination dates, if known.)</i>							
Vaccination / Disease	I	II	III	Last Booster	Antibody Test	Have you had this illness / when?	Office Use Only Immune Status
Hepatitis A					Date: _____ Result: _____		
Hepatitis B					Date: _____ Result: _____		
Mumps					Date: _____ Result: _____		
Rubeola (Measles: Hard, Red, 10-day)					Date: _____ Result: _____		
Rubella: (Measles: German or 3-day)					Date: _____ Result: _____		
Polio							
Tetanus							
Varicella (Chicken Pox)							

- Tuberculosis Screening Done at Employment?     Yes                       No
- Last Skin Test - Date: \_\_\_\_\_ Result: \_\_\_\_\_
- Last Chest X-ray - Date: \_\_\_\_\_ Result: \_\_\_\_\_  
Where: \_\_\_\_\_
- BCG Vaccine: \_\_\_\_\_     Yes                       No

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_