2019/10/7
英語版

Vaccination Questionaire
予防接種問診票

NO.

※接種日

※Please fill in ALL bold boxes.

(ふりがな) Name in Katakana	Date of Birth
Name　　Sex (M ・ F)	Year　Month　Day

	Questions	Answers	
1	Please circle the name of the vaccination(s) you will receive today. Then circle how many times you will have received it, including today's vaccination. (Please note, you can only have up to 2 types of vaccinations per appointment.)	**①Hepatitis A** : (1) (2) **(Additional)**	
		②Tetanus : (1) (2) **(Additional)**	
		③Rabies : (1) (2) (3)	
		④Invasive Meningococcal Disease : (1)	
2	What is your current body temperature?	℃	
3	Did you read and understand the explanation about today's vaccination?	No	Yes
4	Is there any part of you that feels unwell today?	Yes	No
	(Only those who answered "yes") What are your symptoms?		
5	Have you gotten sick within the last month?	Yes	No
	(Only those who answered "yes") What sickness did you have?		
6	Do you have heart, kidney, liver, blood, immune, or other chronic illness?	Yes	No
	(Only those who answered "yes") ① What is the name of your illness?		
	②Did the doctor who is monitoring your illness tell you it was ok to get today's vaccination?	No	Yes
7	Do you have a close realtive who has been diagnosed with congential immunodeficiency?	Yes	No
8	Have you ever had a seizure (convulsions, spasms)?	Yes	No
	(Only those who answered "yes")①When was the last time it happened? (Approximately)	Year	Month (approx.)
	②Did you get a fever that time?	Yes	No
9	Have you ever felt sick or gotten a rash or hives from medicine or food?	Yes	No
10	Have you ever gotten sick after a vaccination?	Yes	No
	(Only those who answered "yes") ①What vaccination was it?		
	②What were you symptoms?		
11	Have you gotten any vaccinations within the past month?	Yes	No
	(Only those who have answered "yes") What was the name of the vaccine?		
12	Within the past month, has anyone in your family or in your surroundings had measles, rubella (three-day measles), chickenpox, mumps, etc.?	Yes	No
	(Only those who answered "yes") What was the name of the illness?		
13	Within the past 6 months, have you had a blood transfusion or gamma globulin vaccination?	Yes	No
14	(Women only) Are you currently pregnant? Is it possible you are pregnant?	Yes	No
15	(Only those who will have a rabies vaccination) Have you ever had an allergic reaction (shock, rash, difficulty breathing, lip edema, laryngeal edema, etc.) to **products or foods containing gelatin?**		
16	(Only those who will have a rabies vaccination) Have you ever had an allergic reaction (shock, rash, difficulty breathing, lip edema, laryngeal edema, etc.) to **products or foods containing egg?**	Yes	No

I understand the effects and side-reaction of the vaccinations and want to be vaccinated.	No	Yes
	Signature	

※以下医療者記入欄※
以上の問診及び診察の結果、今日の予防接種は可能である　はい　・　いいえ **医師署名:**
接種経路及びLot No A型肝炎　筋肉（右 ・ 左）　狂犬病　筋肉（右 ・ 左） Lot No.　Lot No. 破傷風　筋肉（右 ・ 左）　髄膜炎菌　筋肉（右 ・ 左） Lot No.　Lot No. **施行者名サイン:**