# SMALLPOX VACCINATION with ACAM2000 SCREENING FORM

## SECTION A: PATIENT DEMOGRAPHIC INFORMATION

**Title:** _____ **First Name:** _____

**Middle Name:** _____ **Last Name:** _____

**Suffix** (Jr., Sr., M.D., etc.)**:** _____ **Date of Birth:** ____/____/____ (mm/dd/yyyy)

**Age:** _____ **Gender:** ☐ Male ☐ Female ☐ Other

**Street Address:** _____

**Apt #:** _____ **City:** _____

**State:** _____ **Zip code:** _____ **County:** _____

**Contact Information:**

Home Phone: (____) ____-____ Work (____) ____-____ ext.____

Cell Phone (____) ____-____ E-mail Address: _____

Ethnicity/Race: ☐ Hispanic or Latino ☐ Asian ☐ African American ☐ Hawaiian

☐ American Indian or Alaskan ☐ White ☐ Prefer not to answer

**Do you a child in the home less than one year of age?** ☐ Yes ☐ No

**For females only:** First day of last menstrual period: _____

Was your last menstrual period normal and on time? ☐ Yes ☐ No ☐ Unsure

**May we contact you in the future to discuss your vaccination experience?**

☐ Yes ☐ No ☐ Prefer not to answer

## SECTION B: VACCINATION AND MEDICAL HISTORY

**VACCINATION HISTORY**

**Did you ever receive the smallpox vaccine?** ☐ Yes ___/___/____ (mm/dd/yyyy) ☐ No

Use the most recent date if you were vaccinated more than once. If you don't know the date or were vaccinated in childhood, please provide the approximate age you were vaccinated:

_____

***Date:*** _____ ***Patient Name:*** _____

**If yes, did you have any bad reactions to the vaccine (adverse events)?**

☐ Yes ☐ No ☐ Don't Know

If yes, please describe the reaction

_____

**Have you received any vaccination in the last month? (including varicella and COVID-19)**

☐ Yes ☐ No

**Have you had a bad reaction to any vaccine previously?** ☐ Yes ☐ No

**MEDICAL HISTORY**

Are you recovering from recent surgery (including eye or dental)? ☐ Yes ☐ No

Are you currently taking medication? ☐ Yes ☐ No

If yes, please list medications

_____

Are you sick today? ☐ Yes ☐ No

If yes, please describe your illness (you may need to wait to be vaccinated until you get better)

_____

**Do <u>YOU</u> have any of the following conditions?**

**WEAKENED IMMUNE SYSTEM**

1. Do you have any conditions that weaken the immune system such as HIV/AIDS, leukemia, lymphoma, or most other cancers; organ transplant; or primary immune deficiency disorders?

   ☐ Yes ☐ No

2. Do you have a severe autoimmune disease such as lupus that may weaken the immune system?

   ☐ Yes ☐ No

3. Are you now taking, or have you recently taken, drugs that can weaken the immune system like steroids (e.g., prednisone), some medicines for autoimmune disease, or medicines taken after an organ transplant?

   ☐ Yes ☐ No

4. Are you now taking cancer treatment with drugs or radiation or have you taken such treatment in the past 3 months?

   ☐ Yes ☐ No

***Date:*** _____ ***Patient Name:*** _____

**SKIN PROBLEMS**

5. Do you now have, or have you ever had, atopic dermatitis, often called eczema (even as a baby or child and even if the condition is mild)?

   ☐ Yes ☐ No

6. Do you now have other skin problems that have made many breaks in your skin such as a rash, severe burn, impetigo, chickenpox, shingles, herpes, psoriasis, or severe acne?

   ☐ Yes ☐ No

7. Do you have Darier's disease (a skin problem that usually begins in childhood)?

   ☐ Yes ☐ No

**HEART PROBLEMS**

8. Have you ever been diagnosed by a doctor as having a heart condition with or without symptoms such as previous myocardial infarction (heart attack), angina (chest pain caused by lack of blood flow to the heart), congestive heart failure, or cardiomyopathy?

   ☐ Yes ☐ No

9. Have you ever had a stroke or transient ischemic attack (a "mini-stroke" that produces stroke-like symptoms but no lasting damage)?

   ☐ Yes ☐ No

10. Do you have chest pain or shortness of breath when you exert yourself (such as when you walk up stairs)?

    ☐ Yes ☐ No

11. Do you have any other heart condition for which you are under the care of a doctor?

    ☐ Yes ☐ No

12. Do you have three or more of the following risk factors?
    a. You have been told by a doctor that you have high blood pressure.

       ☐ Yes ☐ No

    b. You have been told by a doctor that you have high blood cholesterol.

       ☐ Yes ☐ No

    c. You have been told by a doctor that you have diabetes or high blood sugar.

       ☐ Yes ☐ No

    d. You have a first degree relative (for example mother, father, brother, or sister) who had a heart condition before the age of 50.

       ☐ Yes ☐ No

    e. You smoke cigarettes now.

       ☐ Yes ☐ No

***Date:*** _____ ***Patient Name:*** _____

**PREGNANT OR BREASTFEEDING**

13. Are you pregnant, might be pregnant, or might become pregnant in the next month?

☐ Yes ☐ No

14. In the past month, have you had any sex without using effective birth control or do you think you will have sex without using effective birth control during the month after vaccination?

☐ Yes ☐ No

15. Are you currently breastfeeding or pumping and then bottle-feeding breast milk?

☐ Yes ☐ No

**OTHER**

16. Have you ever had a life-threatening allergic reaction to smallpox vaccine, latex, or the antibiotics polymyxin B, streptomycin, chlortetracycline, or neomycin?

☐ Yes ☐ No

17. Are you now being treated with steroid eye drops?

☐ Yes ☐ No

**Do any of your HOUSEHOLD MEMBERS OR CLOSE PHYSICAL CONTACTS have any of the following conditions?**

Close contacts include anyone living in your household and anyone you have had close physical contact with, such as a sex partner. They do not include friends or co-workers.

**WEAKENED IMMUNE SYSTEM**

1. Do any of your close contacts have conditions that weaken the immune system such as HIV/AIDS, leukemia, lymphoma, or most other cancers; organ transplant; or primary immune deficiency disorders?

☐ Yes ☐ No

2. Do any of your close contacts have a severe autoimmune disease such as lupus that may weaken the immune system?

☐ Yes ☐ No

3. Are any of your close contacts now taking, or have they recently taken, drugs that can weaken the immune system like steroids (e.g., prednisone), some medicines for autoimmune disease, or medicines taken after an organ transplant?

☐ Yes ☐ No

***Date:*** _____ ***Patient Name:*** _____

4. Are any of your close contacts taking cancer treatment with drugs or radiation or have they taken such treatment in the past 3 months?

☐ Yes ☐ No

**SKIN PROBLEMS**

5. Do any of your close contacts now have, or have they ever had atopic dermatitis, often called eczema (even as a baby or child and even if the condition is mild)?

☐ Yes ☐ No

6. Do any of your close contacts now have other skin problems that have made many breaks in their skin such as a rash, severe burn, impetigo, chickenpox, shingles, herpes, psoriasis, severe diaper rash, or severe acne?

☐ Yes ☐ No

7. Do any of your close contacts have Darier's disease (a skin problem that usually begins in childhood)?

☐ Yes ☐ No

**PREGNANCY**

8. Are any of your close contacts pregnant, might be pregnant, or might become pregnant in the next month?

☐ Yes ☐ No

**Screener comments/notes for clarification (for administrative use only)**

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