

National Immunization Survey – Teen Teen Immunization History Questionnaire



Confidential Information. If received in error, please call 1-800-817-4316.

START HERE Please review your records and complete this questionnaire for the adolescent identified on the label to the right. Complete pages 1 and 3 only. Return the questionnaire in the postage-paid envelope or fax toll-free to (866) 324-8659. This information is confidential, if faxing, please take extra care to dial the correct number.

1. Which of the following best describes your immunization records for this adolescent?

You have all or partial immunization records for this adolescent for vaccines given by your practice or other practices.

Was any of the immunization information for this adolescent obtained from your community or state registry? Yes No Don't Know

Go to question 2 below.

Other-Explain

You have provided care to this adolescent, but do not have immunization records.

You have no record of providing care to this adolescent.

Please complete items 5-9 and return form as instructed above.

2. According to your records, what is this adolescent's date of birth?

Month Day Year

Don't know

3. What were the dates of this adolescent's first and most recent visit, for any reason, to this place of practice?

Month Day Year

First Visit

Don't know

Month Day Year

Most Recent Visit

Don't know

4. Did this adolescent receive an 11-12 year old well child exam or check-up at this place?

Yes No Don't know

5. About how many physicians work at this practice, including those who work part-time?

0 1 2 3 4-6 7-10 11 or more

6. Which of the following best describes this facility?

Check only one box, representing the most specific description.

- Federally-qualified health center including community/migrant/rural/Indian health center
- Hospital-based clinic, including university clinic, or residency teaching practice
- Private practice, including solo, group practice, or HMO
- Public health department-operated clinic
- STD clinic/School clinic/Teen clinic
- Other-Explain

Which of the following best describe the main specialties of this facility? Check all that apply.

- Pediatrics Family Practice General Practice
- Internal Medicine OB/GYN
- Other-Explain

7. Does your practice order vaccines from your state or local health department to administer to children?

Yes No Don't know

Not applicable (Practice does not administer vaccines)

8. Did you or your facility report any of this adolescent's immunizations to your community or state registry?

Yes No Don't know

Not applicable (No registry in my community/state)

Not applicable (Practice does not administer vaccines)

9. Contact information for the person returning this form.

Name:

Physician Nurse

Office Manager/ Medical Records

Receptionist Administrator/Technician

Other

Phone: () ext.

Fax: () ext.

10. Go to next page

**Please review the instructions and examples below.
Then complete the “Shot Grid” on the next page.**

Refer to your vaccination records for the adolescent named on the labels on the front cover and next page of this form.

- ▶ Record the month, day and year that each type of shot was given.

EXAMPLE

Vaccine	Date Given			Given by other practice?		Type of Vaccine			
	Month	Day	Year				<i>Mark one box for each vaccine dose received after age 6</i>		
Td/Tdap boosters received after age 6	1	11	18	2002	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap (Adacel® or Boostrix®)	
	2				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap (Adacel® or Boostrix®)	
	3				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap (Adacel® or Boostrix®)	
MMR	1				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> MMR	<input type="checkbox"/> MMR-Varicella	<input type="checkbox"/> Measles only
	2	9	20	2002	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> MMR	<input type="checkbox"/> MMR-Varicella	<input type="checkbox"/> Measles only

- ▶ Be sure to mark the “Yes” or “No” box under “Given by other practice?” for vaccinations given by another practice (see example above).
- ▶ Use the “Other” space to enter any vaccines not listed on the next page or any additional doses of listed vaccines that were given to this adolescent (see example below)

Other	1	11	20	2001	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	} Please do not record Polio, Hib, or Pneumococcal conjugate vaccine (Prevnar®) given before 5 years old	<i>Please enter a description of each vaccine dose</i>	
	2				<input type="checkbox"/> Yes	<input type="checkbox"/> No		TYPHOID	

- ▶ After completing the “Shot Grid” on the next page, please return this form in the envelope provided.
- (Optional)** You may also attach a copy of your immunization history records for this adolescent to this form and send it back to the National Opinion Research Center, National Immunization Survey – Teen, 1 N State St FL 16, Chicago, IL 60602.
- Or you may fax the confidential information to (866) 324-8659. If faxing this form, cut along fold to separate pages, then fax pages 1 and 3. Do not fax this page.

National Immunization Survey – Teen

Please record all vaccination dates in your records for these vaccine types. We realize you might not have the full immunization history of this adolescent.

Vaccine	Date Given			Given by other practice?		Type of Vaccine				
	Month	Day	Year	Yes	No	Mark one box for each vaccine dose received after age 6				
Td/Tdap boosters received after age 6	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap (Adacel® or Boostrix®)			
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap (Adacel® or Boostrix®)			
	3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap (Adacel® or Boostrix®)			
Hepatitis B received since birth	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 0.5 ml Recombivax®	<input type="checkbox"/> 1.0 ml Recombivax®	<input type="checkbox"/> Engerix®	<input type="checkbox"/> HepB only - unknown type	<input type="checkbox"/> HepB-Hib
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 0.5 ml Recombivax®	<input type="checkbox"/> 1.0 ml Recombivax®	<input type="checkbox"/> Engerix®	<input type="checkbox"/> HepB only - unknown type	<input type="checkbox"/> HepB-Hib
	3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 0.5 ml Recombivax®	<input type="checkbox"/> 1.0 ml Recombivax®	<input type="checkbox"/> Engerix®	<input type="checkbox"/> HepB only - unknown type	<input type="checkbox"/> HepB-Hib
	4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 0.5 ml Recombivax®	<input type="checkbox"/> 1.0 ml Recombivax®	<input type="checkbox"/> Engerix®	<input type="checkbox"/> HepB only - unknown type	<input type="checkbox"/> HepB-Hib
Seasonal Influenza received in the past three years	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Injected flu vaccines</u>			<u>Inhaled nasal flu spray</u>	
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fluzone®	<input type="checkbox"/> Fluvirin®	<input type="checkbox"/> Other/Unknown	<input type="checkbox"/> Flumist®	
	3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fluzone®	<input type="checkbox"/> Fluvirin®	<input type="checkbox"/> Other/Unknown	<input type="checkbox"/> Flumist®	
2009 H1N1 (Pandemic) Influenza	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Injected flu vaccines</u>			<u>Inhaled nasal flu spray</u>	
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MIV			<input type="checkbox"/> LAMV	
MMR	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MMR	<input type="checkbox"/> MMR-Varicella	<input type="checkbox"/> Measles only		
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MMR	<input type="checkbox"/> MMR-Varicella	<input type="checkbox"/> Measles only		
Varicella	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Varicella only	<input type="checkbox"/> MMR-Varicella			
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Varicella only	<input type="checkbox"/> MMR-Varicella			
<input type="checkbox"/> Child has a history of chickenpox										
Hepatitis A	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> HepA only (Havrix® or Vaqta®)				
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> HepA only (Havrix® or Vaqta®)				
	3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> HepA only (Havrix® or Vaqta®)				
Pneumococcal polysaccharide	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Meningococcal	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MCV4 (Menactra® or Menveo®)	<input type="checkbox"/> MPSV4 (Menomune®)			
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MCV4 (Menactra® or Menveo®)	<input type="checkbox"/> MPSV4 (Menomune®)			
Human papillomavirus (HPV)	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Gardasil®	<input type="checkbox"/> Cervarix®			
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Gardasil®	<input type="checkbox"/> Cervarix®			
	3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Gardasil®	<input type="checkbox"/> Cervarix®			
Other	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please enter a description of each vaccine dose Please do not record Polio, Hib, or Pneumococcal conjugate vaccine (Prevnar®) given before 5 years old				
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No					

Please remember to answer all questions on page 1.

If you need more space to report vaccines, please attach additional sheets.

Thank you!



Centers for Disease Control and Prevention

U.S. Department of Health and Human Services

Thank you for your help with this important study!

If you would like more information about the National Center for Immunization and Respiratory Diseases, including information about vaccine recommendations or data and statistics from previous years of the National Immunization Survey, please visit the National Immunization Survey website at www.cdc.gov/vaccines.

If you would like more information about the National Immunization Survey, please visit the National Immunization Survey website at www.cdc.gov/nis. If you have any questions or comments about this study, please call (800) 817-4316 or email nis@cdc.gov.

Note: Do NOT send any confidential patient information, such as patient's name or date of birth, in an email message.