National Immunization Survey 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 child identified on the label below. 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. 5b. Which of the following describes this facility? Check all that apply. ☐ Private practice (If yes, select ☐ Solo, ☐ Group, or ☐ Health Maintenance Organization (HMO)) Hospital-based clinic, including university clinic, or residency teaching practice Public health department-operated clinic Community health center Rural Health Clinic 1. Which of the following best describes your immunization ☐ Migrant health center records for this child? Indian Health Service (IHS)-operated center, Tribal health facility, You have all or partial immunization records for this child, for or urban Indian health care facility vaccines given by your practice or other practices. Military health care facility (Army, Navy, Air Force, Marines, Coast Was any of the immunization information for this child Guard) obtained from your community or state registry? ☐ WIC clinic Yes ☐ No ☐ Don't Know ☐ School-based health center Go to question 2 below. Pharmacv ☐ This facility gives immunizations only at birth (hospital). Other-Explain Go to question 2 below. Other-Explain You have provided care to this child, 6. Does your practice order vaccines from your state or local Please complete items but do not have immunization records. health department to administer to children? 5-9 and return form as You have no record of providing care ☐ No instructed above. ☐ Don't know to this child. ■ Not applicable (Practice does not administer vaccines) According to your records, what is this child's date of birth? Month Dav 7. Did you or your facility report any of this child's immunizations to your community or state registry? Don't know Yes No ☐ Don't know 3. What was the date of this child's first visit, for any reason, ☐ Not applicable (No registry in my community/state) to this place of practice? ☐ Not applicable (Practice does not administer vaccines) Month Dav Year ☐ Don't know 8. Contact information for the person returning this form. What was the date of this child's most recent visit, for any reason, to this place of practice? Name: Month Dav Year Physician Nurse Office Manager/Receptionist ■ Medical Records Don't know Administrator/Technician Other 5a. Is your practice a Federally Qualified Health Center (FQHC)) ext. Phone: or Rural Health Clinic (RHC), or a "look alike" FQHC or RHC? Please see Page 4 for definitions. ext. Fax: ☐ Yes No ☐ Don't know 9. 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 child named on the labels on the front cover and next page of this form.

▶ Be sure to mark the box for the correct combination vaccine for each dose as shown in the example below. If the combination included both DTaP and Hib, or HepB and Hib, be sure to enter the information in both vaccine categories. Note that the same vaccine (a combination DTaP-Hib vaccine) is entered under both DTaP and Hib in the example below.

EXAMPLE								
Vac	ccine	Date Given	Given by other practice?	r	Mark one b	Type of Vac		
DTaP		1 11 20 2 11 18	2010 Yes No C	DTaP/DTP DTaP/DTP	DTaP-Hib DTaP-Hib	DTaP-Hep DTaP-Hep Pediarix Penta	B-IPV ^a DTaP-IPV-Hi B-IPV ^a DTaP-IPV-Hi	
Hib		1 11 20 2 11 18		Merck ^a san	ofi ^b GSK ^c G	HepB-Hib ☐ DTa		
•	(see exa	ample above).	or "No" box under or "No" box indica					
Hepatiti Dose 1	i s B 1 given at bi	rth? Yes No	<u>Year</u> 2010			ne box for each value HepB-Hib HepB-Hib	□ DTaP-HepB-IPV^a□ DTaP-HepB-IPV^a	
 ▶ 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 child (see example below). 								
Other	1 2	Month Day 11 20	Year 2011 ☐ Yes ☐ No ☐ Yes ☐ No }	Please enter a description or each vaccine dose.	B('('			
	After	maniating the "Ch	of Cuidly on the most		a watuum th	io form in th	o onvolono provid	- d

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 child to this form and send it back to

NORC at the University of Chicago,

National Immunization Survey

55 East Monroe Street, 19th Floor

Chicago IL 60603

If you choose this option, please answer all questions on page 1.

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.

Vaccine	Date	e Given		practice		Type of Vaccine	
	Month	Day	Year	P		Mark one box for each vaccine dose	
Hepatitis B	1			☐ Yes ☐	No	☐ HepB Only ☐ HepB-Hib ☐ DTaP-HepB-IPVa	
Dose 1 given at	hirth? \ Yes	□ No	IL			_ ,, _ ,, _ ,, _ ,, _ ,, _	
2 000 1 g. 7 0 17 a. C				☐ Yes ☐	No	☐ HepB Only ☐ HepB-Hib ☐ DTaP-HepB-IPV®	
	2			Yes			
	3			=		☐ HepB Only ☐ HepB-Hib ☐ DTaP-HepB-IPV ^a	
	4			☐ Yes ☐	INO	☐ HepB Only ☐ HepB-Hib ☐ DTaP-HepB-IPV ^a	
				_		Mark one box for each vaccine dose	
DTaP	1			☐ Yes ☐	No	☐ DTaP/DTP ☐ DTaP-Hib ☐ DTaP-HepB-IPV® ☐ DTaP-II	PV-Hib ^b
	2			☐ Yes ☐	No	☐ DTaP/DTP ☐ DTaP-Hib ☐ DTaP-HepB-IPV ^a ☐ DTaP-II	PV-Hib ^b
	3			☐ Yes ☐	No	☐ DTaP/DTP ☐ DTaP-Hib ☐ DTaP-HepB-IPV ^a ☐ DTaP-II	PV-Hib ^b
	4			☐ Yes ☐	No	☐ DTaP/DTP ☐ DTaP-Hib ☐ DTaP-HepB-IPV ^a ☐ DTaP-II	PV-Hib ^b
	5			☐ Yes ☐	No	☐ DTaP/DTP ☐ DTaP-Hib ☐ DTaP-HepB-IPV ^a ☐ DTaP-II	PV-Hib ^b
						^a Pediarix ^b Pentacel	
11:15		1	<u> </u>			Mark one box for each vaccine dose	
Hib	1					Merck ^a □ sanofi ^b □ GSK ^c □ HepB-Hib □ DTaP-Hib □ DTaP-IPV-Hib ^c	
	2					Mercka ☐ sanofib ☐ GSKc ☐ HepB-Hib ☐ DTaP-Hib ☐ DTaP-IPV-Hib	
	3					Merck ^a ☐ sanofi ^b ☐ GSK ^c ☐ HepB-Hib ☐ DTaP-Hib ☐ DTaP-IPV-Hib ^c	
	4					Merck ^a ☐ sanofi ^b ☐ GSK ^c ☐ HepB-Hib ☐ DTaP-Hib ☐ DTaP-IPV-Hib ^c	
	5			」 □ Yes □	No	Merck ^a □ sanofi ^b □ GSK ^c □ HepB-Hib □ DTaP-Hib □ DTaP-IPV-Hib ^c *PedvaxHIB*, PRP-OMP *ActHIB*, PRP-T *Hiberix*, booster, PRP-T *Pent	J
						Mark one box for each vaccine dose	.acei
Polio	1			☐ Yes ☐	No	☐ IPV ☐ DTaP-HepB-IPV ^a ☐ DTaP-IPV-Hib ^b ☐ OPV	
	2			☐ Yes ☐		☐ IPV ☐ DTaP-HepB-IPV ^a ☐ DTaP-IPV-Hib ^b ☐ OPV	
	2			☐ Yes ☐		□ IPV □ DTaP-HepB-IPVa □ DTaP-IPV-Hibb □ OPV	
	1			☐ Yes ☐		☐ IPV ☐ DTaP-HepB-IPVa ☐ DTaP-IPV-Hibb ☐ OPV	
	4			100 _	140	Pediarix Pentacel	
				¬		Mark one box for each vaccine dose	
Pneumococcal	1			☐ Yes ☐	No	☐ Conjugate-7 ^a ☐ Conjugate-13 ^b ☐ Polysaccharide ^c	
	2			☐ Yes ☐		☐ Conjugate-7 ^a ☐ Conjugate-13 ^b ☐ Polysaccharide ^c	
	3			_ □ Yes □	No	☐ Conjugate-7 ^a ☐ Conjugate-13 ^b ☐ Polysaccharide ^c	
	4			☐ Yes ☐	No	☐ Conjugate-7 ^a ☐ Conjugate-13 ^b ☐ Polysaccharide ^c	
	5			☐ Yes ☐	No	☐ Conjugate-7 ^a ☐ Conjugate-13 ^b ☐ Polysaccharide ^c	
	6			☐ Yes ☐	No	□ Conjugate-7a □ Conjugate-13b □ Polysaccharide ^c Prevnar® (PCV7) Prevnar13® (PCV13) Pneumovax® (PPSV23)	
			-			*Prevnar* (PCV7) *Prevnar13* (PCV13) *Pneumovax* (PPSV23) Mark one box for each vaccine dose	
Rotavirus (RV)	4			☐ Yes ☐	Nο	☐ RotaTeq® – Merck (RV5) ☐ Rotarix® – GSK (RV1)	
itotarii do (itt)				☐ Yes ☐		☐ RotaTeg® – Merck (RV5) ☐ Rotarix® – GSK (RV1)	
	2			Yes 🗆		☐ RotaTeg® – Merck (RV5) ☐ Rotarix® – GSK (RV1)	
	3				INO		
MMR	,			☐ Yes ☐	No	Mark one box for each vaccine dose ☐ MMR ☐ Measles only ☐ MMR-Varicella	
WINT				Yes		☐ MMR ☐ Measles only ☐ MMR-Varicella	
	2		<u> </u>		INO		
Varicella	,			☐ Yes ☐	No	Mark one box for each vaccine dose □ Varicella only □ MMR-Varicella □ Child has a histor	
Variociia				Yes 🗆		☐ Varicella only ☐ MMR-Varicella ☐ Child has a histor ☐ Varicella only ☐ MMR-Varicella Chickenpox	y or
11 A	2					varicella offiy in whike-varicella smokenpox	
Hepatitis A	1			☐ Yes ☐	No	Please remember to answer all questions on page 1.	٦
	2			」 □ Yes □	No	rouge remained to unemoral questions on page 11	
				_		Mark one box for each vaccine dose	
Seasonal Influenza	1			☐ Yes ☐	No	☐ Inactivated Influenza Vaccine (IIV) ^a ☐ Live Attenuated Influenza Vaccine (IIV)	accine (LAIV) ^t
IIIIueliza	2			☐ Yes ☐	No	☐ Inactivated Influenza Vaccine (IIV) ^a ☐ Live Attenuated Influenza Vaccine	accine (LAIV)
	3			☐ Yes ☐	No	☐ Inactivated Influenza Vaccine (IIV) ^a ☐ Live Attenuated Influenza Vaccine (IIV)	accine (LAIV) ^t
	4			☐ Yes ☐	No	☐ Inactivated Influenza Vaccine (IIV) ^a ☐ Live Attenuated Influenza Vaccine (IIV) ^a	accine (LAIV)
0.0						°Injected, eg. Fluzone® blnhaled nasal flu spray, eg. FluMist®	
Other	1			☐ Yes ☐	No	Please enter a	
	2			☐ Yes ☐		description of	
	3			☐ Yes ☐		each vaccine dose.	
		fyou no	ad more	_		rt vaccines, please attach additional sheets.	
	TI.	you nee	o more	space to re	puil	t vaccines, picase attacii auditional sileets.	

Data Coll Period	Initial	Date	
Progress			
MR or QX rcvd			
Trans complete			
Need Retrieval			
Retrieval Complete			
Edit Complete			
DE Vndr return			

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 CDC Vaccines & Immunization 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 http://www.cdc.gov/vaccines/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.

Definitions:

Federally Qualified Health Center (FQHC): A Federally Qualified Health Center as defined under section 1905(I)(2) of the Social Security Act. FQHCs receive grants under Section 330 of the Public Health Service Act. (B) The term "Federally-qualified health center" means an entity which:

- (i) is receiving a grant under section 330 of the Public Health Service Act[282],
- (ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and
- (II) meets the requirements to receive a grant under section 330 of such Act.

Rural Health Clinic (RHC): A Rural Health Clinic as defined under section 1905(I)(1) of the Social Security Act. A Rural Health Clinic (RHC) is a clinic certified to receive special Medicare and Medicaid reimbursement.

FQHC Look-Alike: An organization that meets all of the eligibility requirements of an organization that receives a PHS Section 330 grant, but does not receive grant funding.