Patient's name Patient's name March Date of brith: Age: years months
Page: years months Proce
Parent/guardian name Prone P
First time vaccination Second time vaccination Third time vaccination Booster vaccination Vaccination history (yysymmytoly) (
Pease fill in the question terms in the bold box below and circle one of the answer columns. Pease fill in the question terms in the bold box below and circle one of the answer columns.
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Please fill in the question items in the bold box below and circle one of the answer columns. Double of the answer columns Body temperature before interview 1.
Cluestionnative for Vaccination
Answer Doctor's commen Leave you read the document (sent to you previously from your city) about the vaccination that will be administered today? No Yes Yes No
2. Please answer about your child's development history. Birth weight (
Birth weight (
Did the child have any abnormal findings after birth? Yes No Have you ever been told any abnormal findings at an infant health check? Yes No If so, describe the specific symptoms. (Did the child have a disease within the last one month? Name of disease (Has any family member or friend of the child had disease such as measles, rubella, chickenpox or mumps within one month? Name of disease: (Has the child been vaccinated in the past month? Name of vaccination (Does the child have a congenital anomaly, heart, kidney, liver, central nerve disease, immune deficiency, or any other diseases for which you have consulted a doctor? Name of vaccination (Does the child have a congenital anomaly, heart, kidney, liver, central nerve disease, immune deficiency, or any other diseases for which you have consulted a doctor? Name of vaccination (Does the child have a congenital anomaly, heart, kidney, liver, central nerve disease, immune deficiency, or any other diseases for which you have consulted a doctor? Name of vaccination (Does the child have a congenital anomaly, heart, kidney, liver, central nerve disease, immune deficiency, or any other diseases for which you have any special medication, such as steroids or immunosuppressants Pass No Has the child have a faver at that time? Has the child have a fewer at that time? Yes No Did the child have a fewer at that time? Yes No 11. Does the child have a family member or relative with a congenital immunodeficiency? Yes No 12. Has the child ever become ill after the vaccination? Yes No 13. Has any family member or relative of the child had a serious reaction to a vaccination in the past? Yes No Entry Column for parent/guardian: Entry column for parent/guardian: Entry column for parent/guardian: Inave been interviewed and explained by the doctor. I have understood the been filt childrens, and is knot a ferice, and also the Relief Entry column for parent/guardian:
Have you ever been told any abnormal findings at an infant health check? 1
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So, describe the specific symptoms. (## 1. Did the child have a disease within the last one month? Name of disease (## 1. Did the child have a disease within the last one month? Name of disease (## 1. Did the child have a disease within the last one month? Name of diseases (## 1. Did the child have a coincent of the child had disease such as measles, rubella, chickenpox or mumps within one month? ## 1. Ves
5. Has any family member or friend of the child had disease such as measles, rubella, chickenpox or mumps within one month? Yes No Name of disease: ())
Name of disease: ())
6. Has the child been vaccinated in the past month? Name of vaccination (7. Does the child have a congenital anomaly, heart, kidney, liver, central nerve disease, immune deficiency, or any other diseases for which you have consulted a doctor? Name of disease (8. Are you currently taking any special medication, such as steroids or immunosuppressants 9. Has the child had a seizure (spasm or fit) in the past? If Yes: age (9. Did the child have a fever at that time? 9. Has the child have a fever at that time? 10. Has the child have a family member or relative with a congenital immunodeficiency? 11. Does the child have a family member or relative with a congenital immunodeficiency? 12. Has the child ever become ill after the vaccination? 13. Has any family member or relative of the child had a serious reaction to a vaccination in the past? 14. Do you have any question about the vaccination? 15. Wes No 16. Do you have any question about the vaccination? 16. Do you have any question about the vaccination? 17. Yes No 18. Entry column for parent/guardian: 18. Lhombis 及び診察の結果、今日の予防接種は (実施できる ・ 見合わせたほうがよい) と判断します。 18. 保護者に対して、予防接種の効果、副反応及び予防接種健康被害教済制度について、説明をしました。 18. 医師署名又は記名押印 18. Entry column for parent/guardian: 18. Lhombis Age Water and risk of serious side effects, and also the Relief the benefit, objectives, and risk of serious side effects, and also the Relief the benefit, objectives, and risk of serious side effects, and also the Relief the benefit, objectives, and risk of serious side effects, and also the Relief the vaccination of the past of vaccination; and risk of serious side effects, and also the Relief the vaccination of vaccinati
Name of vaccination(Date of vaccination; /)
7. Does the child have a congenital anomaly, heart, kidney, liver, central nerve disease, immune deficiency, or any other diseases for which you have consulted a doctor? Name of disease ()) Has the doctor treating disease told you that the child could have the vaccination today? Yes No 8. Are you currently taking any special medication, such as steroids or immunosuppressants Yes No 9. Has the child had a seizure (spasm or fit) in the past? If Yes: age () years old. Yes No 10. Has the child ever had a rash or hives or become ill because of the medications or food? Yes No 11. Does the child have a family member or relative with a congenital immunodeficiency? Yes No 12. Has the child ever become ill after the vaccination? Yes No 13. Has any family member or relative of the child had a serious reaction to a vaccination in the past? Yes No 14. Do you have any question about the vaccination? Yes No 15. Entry column for parent/guardian: Inave been interviewed and explained by the doctor. I have understood the benefit, objectives, and risk of serious side effects, and also the Relief Thave been interviewed and explained by the doctor. I have understood the benefit, objectives, and risk of serious side effects, and also the Relief Thave been interviewed and explained by the doctor. I have understood the benefit, objectives, and risk of serious side effects, and also the Relief Thave the content of the child have a congenital interviewed and explained by the doctor. I have understood the benefit, objectives, and risk of serious side effects, and also the Relief Thave the content of the child have a family property of th
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the benefit, objectives, and risk of serious side effects, and also the Relief コーテトラビック 〒114-0003
System for Health Damage by Vaccination. Now, I confirm my intent on Lot No.
taking vaccination as follows.
(Agree ・ Not agree) (注) 有効期限が切れて 電話 03-3927-3778 いないか要確認
This screening questionnaire is used to improve the safety of vaccination. I understand the above and agree that this questionnaire can be
0.5 mL 接種医師名
接種部位(皮下) Signature of Parent/Guardian or Companion
左 上 腕
右 大 腿 接種 (予診) 年月日 年 月 日