Health Care for the Homeless
INFORMATION RESOURCE CENTER
888/429-3300 • Fax 518/439-7612

#7. CLIENT LOGS
(treatment/progress of individual clients)

Adult health promotion matrix (*WES 5*)
Adult progress notes – Episodic visit (*CAM 12*)
Antiretroviral therapy flow sheet (*MMH 1*)
Case management tracking sheet (*MON 1*)
Case management progress notes (*BAL 50*)
Chronic problem list (*CAM 13*)
Diabetes health promotion matrix (*WES 6*)
Diabetes maintenance form (*CAM 15*)
Health maintenance sheet (*BAL 35*)
HIV flow sheet (*BAL 2*)
HIV specific flow sheet (*CAM 16*)
Issue list (*HPH 1*)
Medication administration record – One time orders (*BAL 39*)
Outreach progress notes (*FAM 3*)
Patient parameters (*WES 4*)
Pediatric progress notes – Episodic visit (*CAM 11*)
Pregnancy referral flow sheet (*POR 1*)
Preventative care data form (*CAM 14*)
Preventive care profile (*BAL 7*)
Progress notes (*BAL 18*)
Social work progress notes (*TER 5*)
TB preventive therapy flow sheet (*MMH 2*)
Vaccine administration record (*WES 3*)

WES 5

MULTNOMAH COUNTY HEALTH DEPARTMENT

Adult Health Promotion Matrix

(See following page for guidelines)

HEALTH EDUCATION

	DATE/INITIALS						
	Personal Health Guide Booklet Given ____						
TOBACCO CESSATION							
ALCOHOL/DRUGS							
HIV/STDs							
HEALTHY DIET							
REGULAR PHYSICAL ACTIVITY							
UNINTENDED PREGNANCY							
OSTEOPOROSIS							
DENTAL HEALTH							
INJURY PREVENTION							
MOTOR VEHICLE INJURY							
FOLIC ACID (PRECONCEPTION)							

EXAMINATION AND TESTS

TEST	INTERVAL							
		DATE						
		RESULT						
		DATE						
		RESULT						
		DATE						
		RESULT						
		DATE						
		RESULT						
		DATE						
		RESULT						
		DATE						
		RESULT						
		DATE						
		RESULT						
		DATE						
		RESULT						
		DATE						
		RESULT						
		DATE						
		RESULT						
		DATE						
		RESULT						
PPD		DATE GIVEN	DATE READ	DATE GIVEN	DATE READ	DATE GIVEN	DATE READ	
		RESULT (mm)		RESULT (mm)		RESULT (mm)		

RESULT CODES: *O = Ordered* *N = Result normal* *A = Result abnormal* *R = Refused* *E = Done Elsewhere* *D = Next due*

IMMUNIZATIONS

INFLUENZA	DATE/SITE									
	SIGNATURE									
ADULT TETANUS/DIPHTHERIA	DATE/SITE					PNEUMOVAX	DATE/SITE			
	SIGNATURE						SIGNATURE			
HEP B	DATE/SITE					HEP A	DATE/SITE			
	SIGNATURE						SIGNATURE			
MMR	DATE/SITE					VARICELLA	DATE/SITE			
	SIGNATURE						SIGNATURE			

CLIENT NAME _____ DATE OF BIRTH _____

See following page for recommended guidelines.

CAM 12

CAMILLUS HEALTH CONCERN INC.
Adult Progress Note / Episodic Visit

Date of Service	Date of Birth	Medical Record	Age	Encounter Number [redacted]

Last Name	First Name	Gender

Vital Signs: BP _____ HR _____ RR _____ WT _____ Temp _____

Allergies:

Living Situation:

F/U Appt _____ Walk In: Chief Complaint _____

_____

acco : never _____ yes _____: _____ ppd x _____; DC'd _____

Alcohol : no ___ significant past use ___ yes ____: amount _____

Drugs: never _____ significant past use _____ active use _____

IVDU ___ Nasal cocaine ___ crack cocaine ___ marij. ___ other____

Medication List - Update

_____
PROVIDERS SIGNATURE

MMH 1

SAINT JOSEPH'S MERCY CARE SERVICES/MERCY MOBILE HEALTH CARE
ANTIRETROVIRAL THERAPY FLOW SHEET

DATE							
THERAPY							
CD4							
VIRAL LOAD							
DATE							
THERAPY							
CD4							
VIRAL LOAD							
DATE							
THERAPY							
CD4							
VIRAL LOAD							
DATE							
THERAPY							
CD4							
VIRAL LOAD							
DATE							
THERAPY							
CD4							
VIRAL LOAD							

MON 1

Case Management Tracking Sheet

Init Contact date_____
ID#_____

ACS CPSE CSE EIP MEDICAID SSI WIC OTHER

****

Child's Name:_____ D.O.B:__/__/___ Age:_____

Parent's Name:_____ D.O.B:__/__/___ Age:_____

Address & Room#:_____ Tel._____

_____

Caseworker Name and #:_____

Date referred to __/__/___: EIP CPSE CSE Speech IMC#_____

Borough or District #_____

Evaluation Site:_____ Contact Person:_____

****

SSI#:_____ SSI office and Tel.#:_____

Analyst Name:_____ Diagnosis_____

****

Date	Calls to Clients	Calls to CW	Calls to Agencies	Car Serv	Letters & Faxes

****

In house use
Please circle one
Q1(Jan-March), Q2(April-June), Q3(July-Sept), Q4(Oct-Dec)
Race
Hispanic White, Black, Other

BAL 50

HEALTH CARE FOR THE HOMELESS **CASE MANAGEMENT PROGRESS NOTE**

DATE:

WHERE STAYED? _____

CONTACT INFORMATION: _____

S: **PRESENTING PROBLEM(S):** _____

_____

_____

_____

_____

O: **APPEARANCE:** APPROPRIATE / INAPPROPRIATE

ATTITUDE: COOPERATIVE / UNCOOPERATIVE / GUARDED / HOSTILE

SPEECH: NORMAL / SLOW / PRESSURED / RAPID / SLURRED

MOOD: NEUTRAL / DYSPHORIC / ANXIOUS / ANGRY / IRRITABLE / EUPHORIC

AFFECT: APPROPRIATE / FLAT / LABILE / INAPPROPRIATE

THOUGHT PROCESS: GOAL DIRECTED / TANGENTIAL / PERSEVERVATIVE / ILLOGICAL / LOOSENING OF ASSOCIATIONS

MEMORY: INTACT / IMPAIRED

JUDGEMENT: GOOD / FAIR / POOR

DOCUMENTS PRESENTED / OTHER: _____

_____

A: **BENEFITS STATUS:**

	CURRENT	PENDING	COMMENTS:
TEMHA			
SSI/SSDI			
F.S.			
PA			
MA			
BUS PASS			

HOUSING STATUS/PLAN: HOUSED? ☐ YES ☐ NO HABC PENDING? ☐ YES ☐ NO

GOALS: _____

ADHERENCE ISSUES: CHRONIC SUBSTANCE ABUSE? ☐ YES ☐ NO CHRONIC MENTAL ILLNESS? ☐ YES ☐ NO

DEVELOPMENT DELAY? ☐ YES ☐ NO

OTHER: _____

DIAGNOSIS: _____

NEEDS ASSOCIATED WITH DIAGNOSIS: _____

TRANSITION ISSUE: NEW CLIENT / NOT HOUSED / UNSTABLE / IN TREATMENT / TRANSITION IN PROGRESS

OTHER: _____

CLIENT LAST NAME: **FIRST:** **HCH#:**

P: BENEFITS: STABLE / NO ACTION / OTHER: _____

HOUSING: STABLE / NO ACTION / OTHER: _____

ADHERENCE: _____

OTHER PROBLEM: _____

NEXT APPT: _____

PROVIDER SIGNATURE: _____ DATE: _____

PRINTED PROVIDER NAME: _____ DATE: _____

COMMENTS: _____

CAM 13

Camillus Health Concern, Inc.

Chronic Problem List

Patient Name ____________________

CHC No. ____________

Date	Problem	Onset	Ongoing	Resolved	Related Studies / Comments	PAS

WES 6

MULTNOMAH COUNTY HEALTH DEPARTMENT

*Optional Diabetes Health Promotion Matrix

* May be used in lieu of Adult Health Promotion Matrix with diabetic patients

(See following page for guidelines)

Personal Health Guide Booklet Given ____

HEALTH EDUCATION

	DATE/INITIALS						
TOBACCO CESSATION							
DRUGS/ALCOHOL							
HIV/STDs							
HEALTHY DIET							
REGULAR PHYSICAL ACTIVITY							
UNINTENDED PREGNANCY							
OSTEOPOROSIS							
DENTAL HEALTH							
INJURY PREVENTION							
MOTOR VEHICLE INJURY							
ASPIRIN PROPHYLAXIS							
DIABETES EDUCATION							
FOLIC ACID (PRECONCEPTION)							

EXAMINATION AND TESTS

TEST	INTERVAL						
		DATE						
		RESULT						
		DATE						
		RESULT						
		DATE						
		RESULT						
		DATE						
		RESULT						
		DATE						
		RESULT						
		DATE						
		RESULT						
Lipid Profile	Annual	DATE						
		RESULT						
Micro Albumin	Annual	DATE						
		RESULT						
Serum Creatinine	Annual	DATE						
		RESULT						
Dilated Eye Exam	Annual	DATE						
		RESULT						
Complete Foot Exam	Annual	DATE						
		RESULT						
PPD		DATE GIVEN	DATE READ	DATE GIVEN	DATE READ	DATE GIVEN	DATE READ	
		RESULT (mm)		RESULT (mm)		RESULT (mm)		

RESULT CODES: *O = Ordered* *N = Result normal* *A = Result abnormal* *R = Refused* *E = Done Elsewhere* *D = Next due*

IMMUNIZATIONS

INFLUENZA	DATE/SITE								
	SIGNATURE								
ADULT TETANUS/DIPHTHERIA	DATE/SITE					PNEUMOVAX	DATE/SITE		
	SIGNATURE						SIGNATURE		
HEP B	DATE/SITE					HEP A	DATE/SITE		
	SIGNATURE						SIGNATURE		
MMR	DATE/SITE					VARICELLA	DATE/SITE		
	SIGNATURE						SIGNATURE		

CLIENT NAME _____ DATE OF BIRTH _____

See following page for recommended guidelines.

CAM 15

Camillus Health Concern, Inc.
Diabetes Maintenance Form

Name: ______________________ **CHC #:** ______________

Date	BG	HbA1C	BP	mAlb	sCR / CrCl	TC/HDL/LDL/TRIG	Foot(S.W.)	Fundoscopy Date
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							
	R F							

Medication Changes:

BAL 35

HEALTH CARE FOR THE HOMELESS, INC.
HEALTH MAINTENANCE SHEET

	CODE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE
HPE Annually										
Ht.	Date									
	Result									
Wt.	Date									
	Result									
Dental Exam										
Vision Exam										
FEMALES										
Mammogram Annually > 40										
Pap Smear										
Breast Exam										
Pt. ed. self-exam										
MALES										
Prostate exam Annually >40 years										
Testicular exam										
Pt. ed. self-exam										
IMMUNIZATION										
Td booster Every 10 years										
Influenza Vacc. Annually										
Pneumo. Vacc.										
Hep. B										
LABS										
PPD	Date									
	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -
Stool occult blood Annually >50 years	Date									
	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -
Cholesterol Every 5 years >35										
HIV Test	Date									
	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -	+ / -
OTHER										

PATIENT LAST NAME: _____ FIRST: _____ HCH#: _____

BAL 2-1

HIV FLOW SHEET

Date Tested Positive __/__/__

Lab Studies

CBC c differential: On Initial work-up, with all CD4's, 2 weeks after initiation of AZT, Every 4 weeks for first three months, then every 3 months

Dates: __/__/__ __/__/__ __/__/__ __/__/__
(Results)

__/__/__ __/__/__ __/__/__ __/__/__

__/__/__ __/__/__ __/__/__ __/__/__

__/__/__ __/__/__ __/__/__ __/__/__

CD4: On initial work-up, then q. 3-6 months if CD4 >600; q. 3-4 months if CD4 200-600; no specific guidelines if CD4 <200. May want to continue to monitor to determine effectiveness of therapy. At milestones for therapy (CD4<500 or <200, repeat CD4 >1 week to confirm results.

Dates: __/__/__ __/__/__ __/__/__ __/__/__
Results: ___ ___ ___ ___

Dates: __/__/__ __/__/__ __/__/__ __/__/__
Results: ___ ___ ___ ___

Dates: __/__/__ __/__/__ __/__/__ __/__/__
Results: ___ ___ ___ ___

Dates: __/__/__ __/__/__ __/__/__ __/__/__
Results: ___ ___ ___ ___

Dates: __/__/__ __/__/__ __/__/__ __/__/__
Results: ___ ___ ___ ___

Date AZT initiated:

Date PCP prophylaxis initiated:

Chemistry: Complete chemistry on initial work-up and yearly; lytes, BUN, creatinine when AZT initiated.

Dates: __/__/__ __/__/__ __/__/__ __/__/__ __/__/__

(Results)

CLIENT NAME_____ HCH #_____

RPR: On initial work-up and yearly.

Dates: __/__/__ __/__/__ __/__/__ __/__/__
Results/titer: ___ ___ ___ ___
(Note any treatment)

Hepatitis Screen: Note dates and tests performed

Dates: __/__/__ __/__/__ __/__/__

Tests:

Results:

History and Physical

On initial work-up, q.6 months if CD4>500, q.3 months if CD4<500.

Dates: __/__/__ __/__/__ __/__/__ __/__/__
__/__/__ __/__/__ __/__/__ __/__/__
__/__/__ __/__/__ __/__/__ __/__/__

Tuberculosis Screening

On initial work-up and yearly according to guidelines.

Dates: __/__/__ __/__/__ __/__/__ __/__/__

PPD result

Anergy result

CXR result

Immunizations

Influenza vaccine: yearly __/__/__ __/__/__ __/__/__

Pneumococcal vaccine: q. 6 years __/__/__ __/__/__

Hepatitis B vaccine __/__/__ (0 months) __/__/__ (1 month) __/__/__ (6 months)

CAM 16

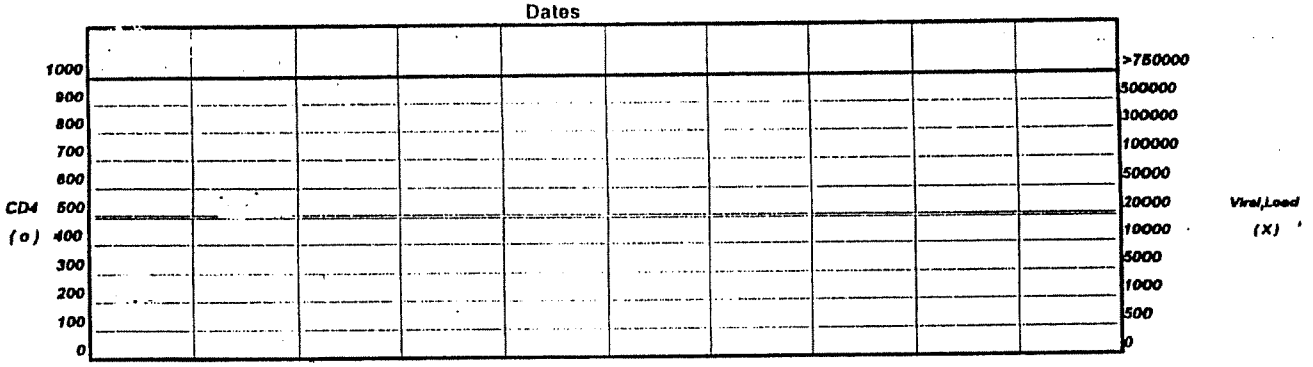
Camillus Health Concern, Inc

Patient Nam

HIV Specific Flow Sheet

CHC No.

Dates



	Date	Result		Date	Result	Date	Result	Date	Result	Date	Result	Date	Result
HBsAg			HIV serology										
HBsAb			RPR										
HCV Ab			Toxo IgG										
G6PD			PPD										
Pneumovax			Influenza										
Td			Recombivax										
CXR													
Pap Smear													
Pap Smear													

Date Sarted	Medication(s), Dosage, Dosing	Date Discontinued

HOMELESS PERSONS HEALTH PROJFCT
Issue List

Date Identified	Client Name:	Date Resolved
	1.	
	2.	
	3.	
	4.	
	5.	
	6.	
	7.	
	8.	
	9.	
	10.	
	11.	
	12.	
	13.	
	14.	
	15.	

FINANCIAL RESOURCES	Date Documented	Date Discontinued
A.		
B.		
C.		
D.		
E.		
F.		
G.		
H.		
I.		
J.		
K.		

AFDC, SSI, VA Benefits, WIC, Wrks Comp., Unemployment, Food Stamps, Wages, Pension, Gen. Assistance, Other, None

BAL 39

HEALTH CARE FOR THE HOMELESS

MEDICATION ADMINISTRATION RECORD - ONE TIME ORDERS

DATE	TIME	NAME OF MEDICATION	DOSAGE/ROUTE	SIGNATURE	SITE

SITE CODE

[RA] - Right Arm **[RL]** - Right Leg **[RB]** - Right Buttock **[ABD]** - Abdomen

[LA] - Left Arm **[LL]** - Left Leg **[LB]** - Left Buttock

CLIENT LAST NAME: **FIRST:** **HCH#:**

FAM 3

OUTREACH PROGRESS NOTE

DATE:_____ NEW/OLD CLINIC LOCATION:_____

SEX: M/F T:_____ P.O./ax/rectal B/P:_____ LMP:_____

Drug Allergies:_____

C/C:_____ MA's Initials:_____

MEDICAL HISTORY:

_____

_____

_____

_____

CURRENT MEDICATIONS:

_____

_____

_____

_____

NOTE FORMAT:

S:
Subjective-Problem as described by patient; history; ADLs as appropriate.

O:
Objective-Physical and laboratory findings.

A:
Assessment-Analysis of S&O.

P:
Plan-Therapy prescribed; diagnostic procedures ordered; instructions given to patients; follow-up planned.

DATES	

Counseled/Instructed on:

___Medication
___Diet
___Exercise
___HIV Risk Factors
___Risks Reviewed
___Substance Abuse
___STDs
___Condoms
___Hospital/Warnings Given
___Tobacco Education
___CAD Risk Factors
___Family Planning

PROVIDER'S SIGNATURE:_____ PROVIDER'S STAMP:_____

SUPERVISOR'S SIGNATURE:_____

PATIENT NAME:_____ D.O.B.:____/____/____ MR#:_____

WES 4

MULTNOMAH COUNTY
HEALTH DEPARTMENT

PATIENT PARAMETERS

Date	Initial / Parameter Monitored	HT	WT	BP	Pulse	Temp	Hgb								

CLIENT NAME

BIRTH DATE

CAM II

CAMILLUS HEALTH CONCERN INC.
Pediatric Progress Note / Episodic Visit

Date of Service	Date of Birth	Med Rec #	Age	Encounter Number

Last Name	First Name	Gender

Vital Signs: Ht _____ Wt _____ Temp _____ Bp _____

HR _____ RR _____ HC _____ Immunizations : Current _____ Defer _____

Allergies: Chief Complaint (walk ins only):_____ _____	***Medication List Update***

_____

PROVIDERS SIGNATURE

POR 1-1

PREGNANCY REFERRAL FLOWSHEET

Homeless Health Program City of Portland Public Health Division

Client: _____ Race: _____ D.O.B. : _____

Address: _____ Telephone: _____

Pregnancy Testing: _____ Date of LMP: _____ Est EDC: _____

Client wishes to continue with pregnancy ☐ Yes ☐ No If "no", provide options counseling and describe here:

For clients planning to continue with pregnancy:

Initials & Date

Explain sources of affordable prenatal care in the community (examples: Family Practice Unit, 871-6809 Ann McDonough, or 874-2466 Mary McDonough Maine Medical Center OB/Gyn Clinic 871-4227, Mercy Hospital Midwifery Clinic, 879-3000 , Mercy Hospital Prenatal 879-3556. _____ _____

Call selected provider: _____ and set up first appointment. _____
Appointment time: _____ Date: _____ To See: _____ _____

☐ Fax an Interagency Referral form to the prenatal provider.

Request that client sign a Release of Information allowing for exchange of information between Public Health and the prenatal provider. _____
☐ Fax or mail the Release of Information to the prenatal provider. _____

Weeks gestational age at onset of prenatal care. This is either the client's first visit to Homeless Clinic or at a prenatal primary care provider (whichever is first) _____weeks _____ _____

Assess for behaviors (drug use, smoking, etc) and health status (HIV, homelessness) which are immediately threatening to successful pregnancy outcome and counsel accordingly. _____ _____

Offer HIV testing. _____ _____

Provide the client with a copy of the positive pregnancy test &/or a note stating the client is pregnant. (Necessary for WIC enrollment). _____ _____

Refer client to WIC. (874-1156. Address is 510 Cumberland Avenue) _____ _____

WIC Details: _____

Explain Maternal Child Health home visiting program available through Portland Public Health and with client's consent, make MCH referral. _____ _____
(By phone 874-8499 or by placing written Prenatal Referral form in B. Weed's mailbox)

Provide client with sufficient prenatal vitamins to last until first prenatal visit. _____
# of vitamins dispensed _____ Type: _____ _____

POR 1-2

PRENATAL FLOW SHEET Page 2

Enter ICD 9 Code for pregnancy, V22.2 on encounter sheet. _____

Client encouraged to return to Homeless Health Program for support, check-in or other care. _____
Details: _____ _____

itials: _____ Signature: _____ Initials: _____ Signature: _____

PREGNANCY OUTCOMES DATA
Homeless Health Program, City of Portland Public Health Division

OUTCOME CRITERIA						
Client's Age	< 15	15-19	20-24	25-44	45+	
Race	Asian	Black	AmInd	White	Hisp	Unreported/ Unknown
Infant Birthweight	1500gm or less	1501-2500	>2500 gm	Gest Age _____wks		
Delivery	Date: _____	Vag	C-sect			
HIV Status Known	Pos	Neg	Unknown			
Enrolled in WIC Prenatally	Yes	No	Unknown			
Mother Postpartum WIC	Yes	No	Unknown			
Infant on WIC	Yes	No	Unknown			
Newborn Visit by 4 wks	Yes	No	Unknown			
Postpartum Visit by 8 wks	Yes	No	Unknown			
Maternal Complications	Yes	No	Unknown			
Newborn Complications	Yes	No	Unknown			

bmw 7/97

CAM 14

Camillus Health Concern, Inc.
Preventative Care Data Form

Name _____ DOB _____ SEX: M F CHC#: _____

_____ JMH#: _____

HIV TESTING:	DATE								
	Result (Pos./Neg.)								
	Location								
	Documentation (Y<N)								

RPR:	DATE								
	Result (titer, NR)								
	Treatment	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	
	Treatment Date Completed								

PPD:	DATE							
	Result (mm, NR)							
	Control POS,, NR)							

DIABETES FUNDOSCOPIC/ PODIATRY:	APPT DATE							FAMILY HISTORY
	Seen (Y, N)							
	Podiatry (DateSeen)							

WOMEN'S HEALTH:	CBE DATE						
	Mammogram Date						
	Pap Smear Date						

DIGITAL RECTAL EXAM:	DATE						
	Prostate (Neg. Abn.)						
	PSA						
	F.O.B. (Pos. / Neg.)						
	Sigmoid/ B. E. Date						

IMMUNIZATIONS	Influenza							
	Pneumococcal							
	Td							

BAL 7

Name _____

HCH # _____

DOB _____

Health Care for the Homeless, Inc.

PREVENTIVE CARE PROFILE

Baseline History and Physical Exam (dates) _____ _____

Family History

CAD	Y	N
Breast Ca	Y	N
DM	Y	N
Colon Ca	Y	N
HTN	Y	N

SEROLOGY

HIV				
RPR				
HBsAg				
Hep C AB				

PHYSICAL EXAM

Exam	Frequency	Dates/Results	Dates/Results	Dates/Results
Breast	Annually			
Pelvic	Every 1-2 years			
Prostate	Annually > 40yr			
Vision	Annually > 60yr			

LABORATORY

Measure	Frequency	Dates/Results	Dates/Results	Dates/Results
Cholesterol	Every 5yrs >35yr			
Hemoccult	Annually > 50yr			
Mammogram	Annually > 50yr			
PAP Smear	Every 1-2 yr.			
PPD	Annually			

IMMUNIZATION

Vaccines/Toxoid	Frequency	Dates	Dates	Dates
Influenza	Annually			
Pneumococcal	Once			
Tetanus	Every 10 yr.			

BAL 18

HEALTH CARE FOR THE HOMELESS

PROGRESS NOTES

DATE	

CLIENT LAST NAME: **FIRST:** **HCH#:**

PROGRESS NOTES

DATE	

TER 5

SOCIAL WORK
PROGRESS NOTES

PROBLEM (No., Title)	(Date)	FINDINGS - PROGRESS NOTES - PLANS

PROGRESS NOTES

PATIENT'S NAME:

RECORD NO. _____

PHONE NO. _____

DATE OF BIRTH _____

WES 3-1

Multnomah County Health Department

Vaccine Administration Record

Information about person to receive vaccine (please print)

Name Last	First	Middle Initial	Birthdate	Age

Address Street	City	County	State	Zip

Sex	Race	Phone Number	Message Number (Optional)

"I have received, read or have had explained to me the Vaccine Information Statement (VIS) on the vaccine(s) to be given. I understand the benefits and risks of the vaccines of the/these vaccine(s) and request that this (they) be given to me or to the person named below for whom I am authorized to make this request."

X _____ Date: _____

Signature of client or person authorized to make the request (parent or guardian)

☐ **DTP DT Td DTaP DTP/HIB**
Dose 1 _____ Dose 2 _____
Dose 3 _____ Dose 4 _____
Dose 5 _____ Adult Booster _____
Vaccine Manufacturer _____
Vaccine Lot No. _____
Site of Injection: _____

☐ **OPV (polio) IPV**
Dose 1 _____ Dose 2 _____
Dose 3 _____ Dose 4 _____
Vaccine Manufacturer _____
Vaccine Lot No. _____
Site of Injection: _____

☐ **Hib or DTP/HIB Combined**
Dose 1 _____ Dose 2 _____
Dose 3 _____ Dose 4 _____
Vaccine Manufacturer _____
Vaccine Lot No. _____
Site of Injection: _____

☐ **MMR**
Dose 1 _____ Dose 2 _____
Vaccine Manufacturer _____
Vaccine Lot No. _____
Site of Injection: _____

☐ **Hepatitis B**
Dose 1 _____ Dosage _____
Dose 2 _____ Dosage _____
Dose 3 _____ Dosage _____
circle cap color: brown yellow green engerix
Vaccine Manufacturer _____
Vaccine Lot No. _____
Site of Injection: _____

☐ **Varicella Flu Hep A Pneum.**
Other _____
Dose 1 _____ Dosage _____
Dose 2 _____ Dosage _____
Vaccine Manufacturer _____
Vaccine Lot No. _____
Site of Injection: _____

VFC Eligibility Codes (circle)

M	Enrolled in Medicaid
N	No health insurance
A	American Indian / Alaskan Native
U	Underinsured
I	Ineligible (none of the above)

Clinic/Office Address	Date Vaccine Given
Signature of Forecaster/Counselor	
Signature and title of Vaccine Administrator	

WES 3-2

Multnomah County
Health Department

Immunization Questionnaire
FOR CHILDREN ONLY

1. Is your child sick right now with anything more serious than a cold? ❒ Yes ❒ No

2. Has your child ever had a convulsion or other problem of the nervous system? ❒ Yes ❒ No

3. Do you have a family history of seizures or convulsions? ❒ Yes ❒ No
This does not mean your child should not receive vaccines although there is a slight increase risk of seizure. If DTP is needed, it is advised to give your child acetaminophen such as Tylenol, at the time of injection and every 4-6 hours for 48-72 hours. If MMR is needed, watch for possible fever 7-12 days following the injection and follow same treatment for fever.

4. Has your child had a serious reaction to DTP shots before, such as: a temperature of 105°F or greater, a convulsion; an episode of limpness and paleness; unusual high-pitched crying; or inflammation of the brain (encephalitis)? ❒ Yes ❒ No

5. Does your child have cancer, leukemia or lymphoma? ❒ Yes ❒ No

6. Does your child have a disease that lowers the body's resistance to infection? ❒ Yes ❒ No

7. Is your child taking a drug that lowers the body's resistance to infection such as cortisone, prednisone, or certain anti-cancer drugs? ❒ Yes ❒ No

8. Does anyone live in your child's household that has any of the conditions listed in #5, #6, or #7 above? ❒ Yes ❒ No

9. Has your child received an immune globulin shot within the last 3 months? ❒ Yes ❒ No

10. Does your child have an allergic reaction to eating eggs so serious that it has required medical treatment? ❒ Yes ❒ No

11. Has your child had an allergic reaction to an antibiotic called neomycin so serious that it required medical treatment? ❒ Yes ❒ No

12. Is your child taking any medications? ❒ Yes ❒ No

FOR ADULTS ONLY

1. Are you sick right now with anything more serious than a cold? ❒ Yes ❒ No

2. Have you ever had a convulsion or other problem of the nervous system? ❒ Yes ❒ No

3. Do you have a family history of seizures or convulsions? ❒ Yes ❒ No

4. Do you have a disease that lowers the body's resistance to infection? ❒ Yes ❒ No

5. Are you taking a drug that lowers the body's resistance to infection such as cortisone, prednisone or certain anti-cancer drugs? ❒ Yes ❒ No

6. Have you received an immune globulin shot with the last 3 months? ❒ Yes ❒ No

7. Do you have an allergic reaction to eating eggs so serious that it has required medical treatment? ❒ Yes ❒ No

8. Have you had an allergic reaction to an antibiotic called neomycin so serious that it required medical treatment? ❒ Yes ❒ No

9. Are you taking any medications? ❒ Yes ❒ No

10. Are you pregnant? ❒ Yes ❒ No