

**Regional Smallpox Vaccination Clinic/SNS
Worker / Volunteer Health Questionnaire
(Bowie, Cass, and Red River Counties)**

The purpose of this screening is to identify if you or a family member have currently known health conditions that may possibly place you or your family members at greater risk for serious side effects should you receive a smallpox vaccination prior to the implementation of any community smallpox vaccination clinics.

Any information that you have provided in this health questionnaire and attached volunteer application may be disclosed to and used by the Smallpox Vaccination Clinic/SNS Planning Committee for planning purposes and volunteer assignment only. Any information you have provided on the health questionnaire will not be disclosed to any individual outside the Smallpox Vaccination Clinic/SNS Planning Committee or for any purpose other than stated above.

(Please circle or ✓ correct answer or answers)

1. Have you ever received a smallpox vaccination? When (if known):	Yes No Don't Know
2. Have you ever had a serious reaction to any vaccine? If so, please describe (type of vaccine and type of reaction):	Yes No
3. Have you ever had an allergic reaction to the antibiotics polymyxin B, streptomycin, tetracycline, or neomycin?	Yes No
4. Do you have 3 or more of the following risk factors: Smoke cigarettes, high blood pressure, high blood cholesterol, diabetes, first-degree relative who had a heart condition before the age of 50?	Yes No
5. Have you had a previous heart attack (also called myocardial infarction)?	Yes No
6. Have you had angina pectoris (chest pain caused by lack of blood flow to the heart)?	Yes No
7. Have you ever been diagnosed with cardiomyopathy?	Yes No
8. Have you ever been diagnosed with congestive heart failure?	Yes No
9. Have you ever had chest pain or shortness of breath with exertion (activity)?	Yes No
10. Do you have any other heart conditions for which you are under the care of a doctor?	Yes No
11. Do you or a household member/close contact have any form of cancer including leukemia?	<input type="checkbox"/> Self Yes No <input type="checkbox"/> Household Yes No
12. Are you or a household member/close contact taking anticancer drugs and/or x-ray or radiation treatments?	<input type="checkbox"/> Self Yes No <input type="checkbox"/> Household Yes No
13. Do you or a household member/close contact have any form of immune system problem such as lupus, agammaglobulinemia, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV)?	<input type="checkbox"/> Self Yes No <input type="checkbox"/> Household Yes No
14. Have you or a household member/close contact had an organ or bone-marrow transplant?	<input type="checkbox"/> Self Yes No <input type="checkbox"/> Household Yes No

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15. Are you or a household member/close contact taking cortisone, prednisone, or other steroids including eye drops containing steroids? (Does not include inhalers)	<input type="checkbox"/> Self Yes No <input type="checkbox"/> Household Yes No
16. Have you, or a household member/close contact ever been told by a doctor that you have eczema or atopic dermatitis?	<input type="checkbox"/> Self Yes No <input type="checkbox"/> Household Yes No
17. Have you or a household member/close contact had an itchy, red, scaly rash that lasts more than 2 weeks and comes and goes?	<input type="checkbox"/> Self Yes No <input type="checkbox"/> Household Yes No
18. Do you or a household member/close contact have any other current skin conditions, such as burns, impetigo, varicella zoster (chickenpox or shingles), psoriasis, herpes or severe or uncontrolled acne?	<input type="checkbox"/> Self Yes No <input type="checkbox"/> Household Yes No
19. Have you or a household member/close contact ever been diagnosed as having Darier's disease? (May also be known as: Darier's syndrome, Darier-White disease, Lutz-Darier syndrome, White's disease, White's syndrome)	<input type="checkbox"/> Self Yes No <input type="checkbox"/> Household Yes No
20. Do you or a household member/close contact have diabetes?	<input type="checkbox"/> Self Yes No <input type="checkbox"/> Household Yes No
21. Are you being treated by a doctor for any other health conditions and want to know if you should be concerned about vaccination?	Yes No
Other issues to be considered at time of receiving smallpox vaccination:	
22. Have you received a transfusion of blood or plasma or any medicine containing antibodies (immune or gamma globulin) in the past 12 months ?	(Not applicable at this time)
23. For women: Could you be pregnant or do you intend to become pregnant in the next 4 weeks? (This information will be important at the time of vaccination).	(Not applicable at this time)
24. Do you have a household member/close contact who is pregnant?	(Not applicable at this time)
25. For women: Are you breastfeeding?	(Not applicable at this time)

Initials _____