



# PARAMOUNT

## URGENT CARE

8640 East CR 466, Suite A  
The Villages, FL 32162  
P- (352) 674-9218  
F- (352) 259-6069

628 Cagan View Road, Suite 4  
Clermont, FL 34714  
P- (352) 242-1988  
F- (352) 242-0866

8972 Turkey Lake Road, Suite A-400  
Orlando, FL 32819  
P- (407) 226-1906  
F- (407) 226-1910

### Shingles Vaccine Screening Questionnaire

1. Are you feeling well today?      Yes      No
2. Do you have allergies to medications, food, or any known vaccines?      Yes      No
3. Have you ever had a serious reaction after receiving a vaccination?      Yes      No
4. Do you have cancer, AIDS, or any other immune system problem?      Yes      No
5. Do you take any of the following: Cortisone, prednisone, anticancer drugs?      Yes      No
6. During the past year, have you received a transfusion of blood or blood products?      Yes      No
7. Women: are you pregnant, or is there a chance that you will become pregnant in the next three months?      Yes      No
8. Have you received any other vaccinations in the past 4 weeks?      Yes      No
9. Are you allergic to Neomycin, or gelatin?      Yes      No
10. Are you 60 years of age or older?      Yes      No
11. Have previously had chickenpox?      Yes      No

### Patient Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Phone Number \_\_\_\_\_ Email address \_\_\_\_\_

### Participant Consent

I have read the information provided by Paramount Urgent Care regarding the Shingles Vaccination, and acknowledge that the above information has been answered correctly to the best of my ability. I consent to receiving the Shingles (Herpes Zoster) vaccination.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

### For Office Use Only

Clinic Location: \_\_\_\_\_  
 The Villages     Clermont     Orlando

BATCH # AND EXPIRATION DATE: \_\_\_\_\_

ADMINISTERED BY: \_\_\_\_\_ INJECTION SITE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_