REGION SÖRMLAND

Pneumococcal vaccination questionnaire

Patient details:

Name Personal ID number

Before your pneumococcal vaccination, please answer the following questions:

1. Are you currently suffering from a fever and/or an acute infection? Yes ☐ No ☐
2. Have you previously had any problems with vaccinations? Yes ☐ No ☐
3. Have you suffered a serious allergic reaction before? Yes ☐ No ☐
4. Are you regularly taking any anticoagulants, such as Waran? Yes ☐ No ☐
5. Have you been vaccinated against pneumococcal bacteria before? Yes ☐ No ☐

- Which year did you have the pneumococcal vaccine?_____

6. Are you in a medical risk group, such as: Yes ☐ No ☐

- No spleen or non-functioning spleen
- Skull fracture or CSF leak
- Chronic heart, lung or kidney disease
- High alcohol consumption or alcoholism
- Welder with extensive exposure to toxic smoke
- Cochlear implant for improved hearing
- Impaired immune system due to illness or medication (such as HIV, lymphoma or chemotherapy)
- Age 65 or older
- Diabetes
- Smoker with lung damage
- Cirrhosis of the liver

7. Are you pregnant? Pregnant women are <u>not</u> to receive the vaccine! Yes ☐ No ☐

Name: _____ Signature: _____

The following section will be completed by the vaccination clinic

Vaccinationsdatum:	Ordinatörens namn:
Pneumovax ☐	Administreringssätt: Hö arm ☐ i.m. ☐ s.c. ☐ Vä arm ☐ i.m. ☐ s.c. ☐
Batch-/lotnummer:	Ev. annan lokalisation för administrering:
Ev. kommentar:	
Vaccinationen registrerad i Svevac ☐	