OMB No. XXXX-XXXX; Approval Expires XX/XX/XXXX

National Immunization Survey Evaluation Study

Immunization History Questionnaire

FORM **7317-IHQ**
(3-3-2009)

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU

ACTING AS DATA COLLECTION AGENT FOR THE
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Immunization and Respiratory Diseases

START HERE → Please review your records and complete this questionnaire for the child identified on the label to the right. Complete pages 1 and 3 only. Return the questionnaire in the postage-paid envelope or fax to (812) 218–3678. This information is confidential, if faxing, please take extra care to dial the correct number.

1. Which of the following best describes your Immunization records for this child?

1 ☐ You have all or partial immunization records for this child, for vaccines given by your practice or other practices.
→ Was any of the immunization information for this child obtained from your community or state registry?
1 ☐ Yes 2 ☐ No 3 ☐ Don't know
Go to question 2 below.

2 ☐ This facility gives immunizations only at birth (hospital).
Go to question 2 below.

3 ☐ Other – *Explain* ↙

4 ☐ You have provided care to this child, but do not have immunization records.

5 ☐ You have no record of providing care to this child.

Please complete items 5–9 and return form as instructed above.

2. According to your records, what is this child's date of birth?

Month | Day | Year

3 ☐ Don't know

3. What was the date of this child's FIRST visit, for any reason, to this place of practice?

Month | Day | Year

3 ☐ Don't know

4. What was the date of this child's MOST RECENT visit, for any reason, to this place of practice?

Month | Day | Year

3 ☐ Don't know

5. How many physicians work at this practice, including those who work part-time?

1 ☐ 1 3 ☐ 3 5 ☐ 7–10
2 ☐ 2 4 ☐ 4–6 6 ☐ 11 or more

6. Which of the following best describes this facility? Check only one box, representing the most specific description.

1 ☐ Federally-qualified health center including community/migrant/rural/Indian health center
2 ☐ Hospital-based clinic, including university clinic, or residency teaching practice.
3 ☐ Private practice, including solo, group practice, or HMO.
4 ☐ Public health department-operated clinic
5 ☐ Military health care facility
6 ☐ WIC clinic
7 ☐ Other – *Explain* ↙

7. Does your practice order vaccines from your state or local health department to administer to children?

1 ☐ Yes 2 ☐ No 3 ☐ Don't know
4 ☐ Not applicable (Practice does not administer vaccines)

8. Did you or your facility report any of this child's immunizations to your community or state registry?

1 ☐ Yes 2 ☐ No 3 ☐ Don't know
4 ☐ Not applicable (No registry in my community/state)
5 ☐ Not applicable (Practice does not administer vaccines)

9. Contact information for the person returning this form.

Name: _____

1 ☐ Physician
2 ☐ Office Manager/
3 ☐ Receptionist
4 ☐ Other
5 ☐ Nurse
6 ☐ Medical Records Administrator/Technician

Telephone number	Fax number

10. *Go to next page* →

Please review the instructions and examples below. Then complete the "Shot Grid" on the next page.

Refer to your vaccination records for the child named on the labels on the front cover and next page of this form.

▶ **Be sure to mark the box for the correct combination vaccine for each dose as shown in the example below. If the combination included both DTaP and Hib, or HepB and Hib, be sure to enter the information in both vaccine categories. Note that the same vaccine (a combination DTap-Hib vaccine) is entered under both DTaP and Hib in the example below.**

EXAMPLE

Vaccine		Date Given (Month / Day / Year)	Given by other practice	Type of Vaccine (*Mark one box for each vaccine dose*)
DTaP	**1**	11 / 20 / 2006	1 ☐ Yes 2 ☒ No	1 ☐ DTaP/DTP 2 ☐ DTaP-Hib 3 ☒ DTaP-HepB-IPV 4 ☐ DTap-IPV-Hib
	2	11 / 18 / 2007	1 ☒ Yes 2 ☐ No	1 ☐ DTaP/DTP 2 ☒ DTaP-Hib 3 ☐ DTaP-HepB-IPV 4 ☐ DTap-IPV-Hib
Hib	**1**	11 / 20 / 2006	1 ☐ Yes 2 ☒ No	1 ☐ Hib-Merck* 2 ☐ Hib-sanofi** 3 ☐ HepB-Hib 4 ☒ DTap-Hib 5 ☐ DTaP-IPV-Hib
	2	11 / 18 / 2007	1 ☒ Yes 2 ☐ No	1 ☒ Hib-Merck* 2 ☐ Hib-sanofi** 3 ☐ HepB-Hib 4 ☐ DTap-Hib 5 ☐ DTaP-IPV-Hib

▶ **Be sure to mark the "Yes" or "No" box under "Given by other practice?" for each vaccination (see example above).**

▶ **Be sure to mark the "Yes" or "No" box indicating "Given at birth?" for the first Hep B dose (see example below).**

Vaccine		Date Given (Month / Day / Year)	Given by other practice	Type of Vaccine (*Mark one box for each vaccine dose*)
Hepatitis B	**1**	07 / 19 / 2006	1 ☒ Yes 2 ☐ No	1 ☒ HepB Only 2 ☐ HepB-Hib 3 ☐ DTaP-HepB-IPV
Dose 1 given at birth? 1 ☒ Yes 2 ☐ No	**2**		1 ☐ Yes 2 ☐ No	1 ☐ HepB Only 2 ☐ HepB-Hib 3 ☐ DTaP-HepB-IPV

▶ **Use the "Other" space to enter any vaccines not listed on the next page or any additional doses of listed vaccines that were given to this child (see example below).**

Vaccine		Date Given (Month / Day / Year)	Given by other practice	*Please enter a description of each vaccine dose.*
Other	**1**	11 / 20 / 2007	1 ☐ Yes 2 ☒ No	BCG
	2		1 ☐ Yes 2 ☐ No	

▶ **After completing the "Shot Grid" on the next page, please return this form in the envelope provided.**

(Optional) You may also attach a copy of your Immunization history records for this child to this form and send it back to the U.S. Census Bureau, Attention SPB/DSPU/64C, 1201 E 10th Street, Jeffersonville, IN 47132-0001. If you choose this option, please answer all questions on page 1.

Or you may fax this confidential information to (812)218–3678. If faxing this form, separate the pages and fax pages 1 and 3. Do not fax this page.

Vaccine		Date Given (Month / Day / Year)	Given by other practice?	Type of Vaccine
Hepatitis B	1		1 Yes 2 No	1 HepB Only 2 HepB-Hib 3 DTaP-HepB-IPV
Dose 1 given at birth? 1 Yes 2 No				
	2		1 Yes 2 No	1 HepB Only 2 HepB-Hib 3 DTaP-HepB-IPV
	3		1 Yes 2 No	1 HepB Only 2 HepB-Hib 3 DTaP-HepB-IPV
	4		1 Yes 2 No	1 HepB Only 2 HepB-Hib 3 DTaP-HepB-IPV
DTaP	1		1 Yes 2 No	1 DTaP/DTP 2 DTaP-Hib 3 DTaP-HepB-IPV 4 DTaP-IPV-Hib
	2		1 Yes 2 No	1 DTaP/DTP 2 DTaP-Hib 3 DTaP-HepB-IPV 4 DTaP-IPV-Hib
	3		1 Yes 2 No	1 DTaP/DTP 2 DTaP-Hib 3 DTaP-HepB-IPV 4 DTaP-IPV-Hib
	4		1 Yes 2 No	1 DTaP/DTP 2 DTaP-Hib 3 DTaP-HepB-IPV 4 DTaP-IPV-Hib
	5		1 Yes 2 No	1 DTaP/DTP 2 DTaP-Hib 3 DTaP-HepB-IPV 4 DTaP-IPV-Hib
Hib	1		1 Yes 2 No	1 Hib-Merck* 2 Hib-sanofi** 3 HepB-Hib 4 DTaP-Hib 5 DTaP-IPV-Hib
	2		1 Yes 2 No	1 Hib-Merck* 2 Hib-sanofi** 3 HepB-Hib 4 DTaP-Hib 5 DTaP-IPV-Hib
	3		1 Yes 2 No	1 Hib-Merck* 2 Hib-sanofi** 3 HepB-Hib 4 DTaP-Hib 5 DTaP-IPV-Hib
	4		1 Yes 2 No	1 Hib-Merck* 2 Hib-sanofi** 3 HepB-Hib 4 DTaP-Hib 5 DTaP-IPV-Hib
	5		1 Yes 2 No	1 Hib-Merck* 2 Hib-sanofi** 3 HepB-Hib 4 DTaP-Hib 5 DTaP-IPV-Hib
Polio	1		1 Yes 2 No	1 OPV 2 IPV 3 DTaP-HepB-IPV 4 DTaP-IPV-Hib
	2		1 Yes 2 No	1 OPV 2 IPV 3 DTaP-HepB-IPV 4 DTaP-IPV-Hib
	3		1 Yes 2 No	1 OPV 2 IPV 3 DTaP-HepB-IPV 4 DTaP-IPV-Hib
	4		1 Yes 2 No	1 OPV 2 IPV 3 DTaP-HepB-IPV 4 DTaP-IPV-Hib
Pneumo-coccal	1		1 Yes 2 No	1 Conjugate 2 Polysaccharide
	2		1 Yes 2 No	1 Conjugate 2 Polysaccharide
	3		1 Yes 2 No	1 Conjugate 2 Polysaccharide
	4		1 Yes 2 No	1 Conjugate 2 Polysaccharide
Rotavirus	1		1 Yes 2 No	1 RotaTeq® – Merck 2 Rotarix® – GSK
	2		1 Yes 2 No	1 RotaTeq® – Merck 2 Rotarix® – GSK
	3		1 Yes 2 No	1 RotaTeq® – Merck 2 Rotarix® – GSK
MMR	1		1 Yes 2 No	1 MMR 2 Measles only 3 MMR-Varicella
	2		1 Yes 2 No	1 MMR 2 Measles only 3 MMR-Varicella
Varicella	1		1 Yes 2 No	1 Varicella only 2 MMR-Varicella
	2		1 Yes 2 No	1 Varicella only 2 MMR-Varicella
Hepatitis A	1		1 Yes 2 No	
	2		1 Yes 2 No	
Influenza	1		1 Yes 2 No	1 TIV (*Injected flu vaccines (e.g., Fluzone®)*) 2 LAIV (*Inhaled nasal flu spray (e.g., FluMist®)*)
	2		1 Yes 2 No	1 TIV 2 LAIV
	3		1 Yes 2 No	1 TIV 2 LAIV
	4		1 Yes 2 No	1 TIV 2 LAIV
Other	1		1 Yes 2 No	
	2		1 Yes 2 No	
	3		1 Yes 2 No	

Mark one box for each vaccine dose

*PedvaxHIB®, PRP-OMP **ActHIB®, PRP-T

Please remember to answer all questions on page 1.

Please enter a description of each vaccine dose.

If you need more space to report vaccines, please attach additional sheets.

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Thank You for your help with this important Study!

Please return this questionnaire in the included postage paid envelope or send to this address:

U.S. Census Bureau
Attention: SPB/DSPU/64C
1201 E 10th Street
Jeffersonville, IN 47132-0001

In Partnership with

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

If you would like more information about the vaccine recommendations, or data and statistics, go to www.cdc.gov/vaccines.

If you have any questions or comments about this study, please call (XXX) XXX–XXXX.

Notice – Public reporting burden for this collection of information is estimated to average 15 minutes or less per questionnaire, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The U.S. Office of Management and Budget (OMB) approved this survey and gave it OMB approval Number of 0607-XXX. Displaying this number shows that the Census Bureau is authorized to conduct this survey. Please use this number in any correspondence concerning this survey.

Assurances of Confidentiality – The law authorizes the Census Bureau to collect information for this survey (Title 13, United States Code (U.S.C.), Section 182). Section 9 of this law requires us to keep all information about you and your household strictly confidential. The Census Bureau will use this information only for statistical purposes. Everyone who has access to your responses is subject to a prison term, a fine up to $250,000, or both, if any information is revealed that identifies you or your household.