National Health Interview Provider Survey — Teen Teen Immunization History Questionnaire



Confidential Information. If received in error, please call 1-800-817-4316.

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th th to	TART HERE omplete this le label to the le questionna (866) 324-86 lease take ex	question e right. Caire in the 659. This	naire for tomplete e postage informat	pages 1 an -paid envel ion is confi									
	1. Which of the following best describes your immunization records for this adolescent? You have all or partial immunization records for this adolescent for vaccines given by your practice or other practices. Was any of the immunization information for this adolescent obtained from your community or state registry? Yes No Don't Know Go to question 2 below. Other-Explain You have provided care to this adolescent, but do not have immunization records. You have no record of providing care to this adolescent. Please complete item 9 and return form as instructed above. According to your records, what is this adolescent's date of birth? Month Day Year							6. Which of the following best describes this facility? Check only one box, representing the most specific description. Federally-qualified health center including community/migrant/rural/Indian health center. Hospital-based clinic, including university clinic, or residence teaching practice. Private practice, including solo, group practice, or HMO. Public health department-operated clinic STD clinic/School clinic/Teen clinic Other-Explain Which of the following best describe the main specialties of this facility? Check all that apply. Pediatrics Family Practice General Practic Internal Medicine OB/GYN Other-Explain					
3. What were the dates of this adolescent's <u>first</u> and <u>most recent</u> visit, for any reason, to this place of practice?							sta	oes your practice order vaccines from your ate or local health department to administer to nildren? Yes No Don't know id you or your facility report any of this adolescent's					
	First Visit	Month Month	<u>Day</u> <u>Day</u>	Year Year	☐ Don't know	9.	im	The your facility report any of this adolescent sommunizations to your community or state registry? Yes No Don't know Not applicable (No registry in my community/state) ontact information for the person returning this orm.					
A. Did this adolescent receive an 11-12 year old well child exam or check-up at this place? Yes No Don't know							Na	Ame: Physician Office Manager/ Receptionist Administrator/Technician Other					
5. About how many physicians work at this practice, including those who work part-time?							Fax	none: () ext.					

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

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

▶ Record the month, day and year that each type of shot was given.

EXAMPLE											
Vaccine	Date Given			Given by oth practice?	er Type of Vaccine						
Tetanus boosters	Month 1 11	<u>Day</u>	<u>Year</u> 2002	☐ Yes	lo						
MMR	1 9 2	20	2002	Yes I	lo lo						

- ▶ Be sure to mark the "Yes" or "No" box under "Given by other practice?" for vaccinations given by another practice (see example above).
- ▶ 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 adolescent (see example below)

Other	1 11	20	2001	X Yes	□ No l	Please do not record Polio, Hib, or Pneumococcal	Please enter a description of each vaccine dose TYPHOID
	2			Yes	□No	conjugate	
						vaccine (Prevnar) given before 5	
						years old	

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 adolescent to this form and send it back to the National Opinion Research Center, National Immunization Survey – Teen, 1 N State St FL 16, Chicago, IL 60602.

Or you may fax the confidential information to (866) 324-8659. If faxing this form, cut along fold to separate pages, then fax pages 1 and 3. Do not fax this page.

National Immunization Survey – Teen
Please record all vaccination dates in your records for these vaccine types. We realize you might not have the full immunization history of this adolescent.

Vaccine		Date Giv	en		by other ctice?	•		Type of	Vaccine	
	<u>Month</u>	<u>Day</u>	<u>Year</u>			Mark one b	ox for each	vaccine dos	se received after a	ige 6
Td/Tdap boosters	1			Yes	☐ No	☐ Td ☐ Te	dap (Adacel	or Boostrix)		
	2			Yes	☐ No	☐ Td ☐ Te	dap (Adacel	or Boostrix)		
age 6	3			Yes	☐ No	☐ Td ☐ Te	dap (Adacel	or Boostrix)		
							НерВ	only		
Hepatitis B received since	1			Yes	□ No		.0 ml [ecombivax	Engerix	HepB only - unknown type	HepB-Hib
birth	2			Yes	□No	□ 0.5 ml □ 1.	.0 ml [ecombivax	Engerix	HepB only - unknown type	☐ HepB-Hib
	3			Yes	□No		.0 ml [ecombivax	Engerix	HepB only - unknown type	☐ HepB-Hib
	4			Yes	□ No		.0 ml [ecombivax	Engerix	HepB only - unknown type	HepB-Hib
						Injecte	ed flu vaccir	nes	Inhale	d nasal flu spray
Influenza received in the	1			Yes	☐ No	Fluzone Fl	uvirin [Other/Unk	cown	Flumist
past three				Yes Yes	☐ No	Fluzone Fluzone	uvirin [Other/Unk	kown	Flumist
years	3			Yes	□ No	Fluzone Fluzone	uvirin [Other/Unk	cown	Flumist
MMR	1			Yes	□ No	□ MMR □ M	MR-Varicella	a \square Mea	sles only	
	2			Yes	□ No	□ MMR □ M	MR-Varicella		sles only	
Varicella	1			Yes	□ No	Varicella only	☐ MMR-Var	ricella		
	2			Yes	□ No	☐ Varicella only ☐	☐ MMR-Var	ricella		
☐ Child ha	as a histor	y of chic	kenpox							
Hepatitis A	1			Yes	□ No	HepA only (Havrix	or Vanta)			
	2			Yes	□ No	HepA only (Havrix				
	3			Yes	□ No	HepA only (Havrix				
		<u>'</u>				<u> </u>				
Pneumococcal polysaccharide				Yes	□ No					
polysaccilarius	2			Yes	□ No					
Meningococca	 a	1			П.,			(0.0		
g	' <u> </u>			☐ Yes☐ Yes	□ No	MCV4 (Menactra)	_	` ′		
	2			L Yes	LI IVO	MCV4 (Menactra)	LI IVIPSV4	(Menornane)		
Human papillomavirus	1			Yes	□ No					
(HPV)				Yes	□ No	Places rome	mhor to	anowar	all augotions	on nago 1
	3			Yes	□ No	Please reme	iiibei to	aliswei	an questions	un paye i
Other	4	1				Diamenta de	Pleas	e enter a de	escription of each	vaccine dose
Other	1			☐ Yes		Please do not record Polio, Hib,				
	3			☐ Yes	□ No	or Pneumococcal conjugate				
	4			☐ Yes		vaccine (Prevnar)				
	5			☐ Yes☐ Yes		given before 5 years old				
	J	If your	LEED mor		INO	vaccines, please	attach ac	ditional s	heets	

Thank you!



Centers for Disease Control and Prevention

U.S. Department of Health and Human Services

Thank you for your help with this important study!

If you would like more information about the National Center for Immunization and Respiratory Diseases, including information about vaccine recommendations or data and statistics from previous years of the National Immunization Survey, please visit the National Immunization Survey website at www.cdc.gov/vaccines.

If you would like more information about the National Immunization Survey, please visit the National Immunization Survey website at www.cdc.gov/nis. If you have any questions or comments about this study, please call (800) 817-4316 or email nis@cdc.gov.

Note: Do **NOT** send any confidential patient information, such as patient's name or date of birth, in an email message.

Notice - Public reporting burden for this collection of information is estimated to average 5 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing burden to: CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0212).

Assurances of Confidentiality – All information which would permit identification of any individual, a practice, or an establishment will be held confidential, will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).