## National Health Interview Provider Survey Immunization History Questionnaire



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

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on only env info	Please review your records an applete this questionnaire for the child identify the label to the right. Complete pages 1 and y. Return the questionnaire in the postage-prelope or fax toll-free to (866) 324-8659. To the confidential, if faxing, please the care to dial the correct number.		
1.	Which of the following best describes your Immunization records for this child?  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? Yes No Don't Know Go to question 2 below.  This facility gives immunizations only at birth (hospital). Go to question 2 below.  Other-Explain  You have provided care to this child, but do not have immunization records.  You have no record of providing care to this child.	7.	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 residency teaching practice.  Private practice, including solo, group practice, or HMO.  Public health department-operated clinic  Military health care facility  WIC clinic  Other-Explain  Does your practice order vaccines from your state or local health department to administer to children?
2.	According to your records, what is this child's date of birth?  Month Day Year  Don't know	8.	☐ Yes ☐ No ☐ Don't know  Did you or your facility report any of this child's immunizations to your community or state registry?  ☐ Yes ☐ No ☐ Don't know
<ol> <li>4.</li> </ol>	What was the date of this child's <u>first</u> visit, for any reason, to this place of practice?  Month Day Year  Don't know  What was the date of this child's <u>most recent</u> visit, for any reason, to this place of practice?  Month Day Year	9.	Not applicable (No registry in my community/state)  Contact information for the person returning this form.  Name:  Physician  Office Manager/ Receptionist  Administrator/Technician  Other
5.	How many physicians work at this practice, including those who work part-time?  1	10.	Phone: ( ) ext.  Fax: ( ) ext.  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, DTP 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 DTP and Hib in the example below.

		EXA	MPLE					
Vaccir	ne Date Given	Given by other practice	Type of Vaccine					
DTP	Month         Day         Year           1         11         20         2005           2         11         18         2006	Yes No No Yes No	Mark one box for each vaccine dose  ☐ DTP ☐ DTaP ☒ DTaP-Hib ☐ DTP-Hib ☐ DTaP-HepB-IPV ☐ DTP ☒ DTaP ☐ DTaP-Hib ☐ DTP-Hib ☐ DTaP-HepB-IPV					
Hib	1 11 20 2005 2 11 18 2006	Yes No	Mark one box for each vaccine dose   ☐ Hib ☐ HepB-Hib ☐ DTaP-Hib ☐ DTP-Hib   ☐ Hib ☐ HepB-Hib ☐ DTaP-Hib ☐ DTP-Hib					
<b>•</b>	example above).		'Given by other practice?" for each vaccination (see ing "Given at birth?" for the first Hep B dose (see					
Hepatiti Dose 1	Month   Day   Year     S B   1   07   19   2005     given at birth?   Yes □ No     2	Yes No	Mark one box for each vaccine dose  ☐ HepB Only ☐ HepB-Hib ☐ DTaP-HepB-IPV  ☐ HepB Only ☐ HepB-Hib ☐ 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).								
Other	Month         Day         Year           1         11         20         2006           2	Yes No No V	lease enter description f each accine ose.  BCG					

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 National Opinion Research Center, National Immunization Survey, 1 N State St FL 16, Chicago, IL 60602. If you choose this option, please answer all questions on page 1.

Or you may fax this 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.

Vaccine	Date Given	practice?	Type of Vaccine
	Month Day Year	•	Mark one box for each vaccine dose
Hepatitis B	1	Yes No	☐ HepB Only ☐ HepB-Hib ☐ DTaP-HepB-IPV
	n at birth? ☐ Yes ☐ No	1	
	2	Yes No	☐ HepB Only ☐ HepB-Hib ☐ DTaP-HepB-IPV
		i — —	
	3	J ∐ Yes ∐ No	☐ HepB Only ☐ HepB-Hib ☐ DTaP-HepB-IPV
	4	」 ∐ Yes ☐ No	☐ HepB Only ☐ HepB-Hib ☐ DTaP-HepB-IPV
			Mark one box for each vaccine dose
DTP	1	∐ Yes ∐ No	□ DTP □ DTaP □ DTaP-Hib □ DTP-Hib □ DTaP-HepB-IPV
	2	∐ Yes ∐ No	☐ DTP ☐ DTaP ☐ DTaP-Hib ☐ DTP-Hib ☐ DTaP-HepB-IPV
	3	Yes No	□ DTP □ DTaP □ DTaP-Hib □ DTP-Hib □ DTaP-HepB-IPV
	4	Yes No	☐ DTP ☐ DTaP ☐ DTaP-Hib ☐ DTP-Hib ☐ DTaP-HepB-IPV
	5	Yes No	DTP DTaP DTaP-Hib DTP-Hib DTaP-HepB-IPV
			Mark one box for each vaccine dose
Hib	1	Yes No	Hib HepB-Hib DTaP-Hib DTP-Hib
1115	2	Yes No	☐ Hib ☐ HepB-Hib ☐ DTaP-Hib ☐ DTP-Hib
		i — —	
	3	☐ Yes ☐ No	☐ Hib ☐ HepB-Hib ☐ DTaP-Hib ☐ DTP-Hib
	4	∐ Yes ∐ No	☐ Hib ☐ HepB-Hib ☐ DTaP-Hib ☐ DTP-Hib
	5	」	☐ Hib ☐ HepB-Hib ☐ DTaP-Hib ☐ DTP-Hib
			Mark one box for each vaccine dose
Polio	1	∐ Yes ∐ No	☐ OPV ☐ IPV ☐ DTaP-HepB-IPV
	2	☐ Yes ☐ No	☐ OPV ☐ IPV ☐ DTaP-HepB-IPV
	3	Yes No	☐ OPV ☐ IPV ☐ DTaP-HepB-IPV
	4	Yes No	OPV IPV DTaP-HepB-IPV
			Mark one box for each vaccine dose
Pneumo-	1	Yes No	☐ Conjugate ☐ Polysaccharide
coccal	2	Yes No	☐ Conjugate ☐ Polysaccharide
	3	Yes No	☐ Conjugate ☐ Polysaccharide
	4	Yes No	☐ Conjugate ☐ Polysaccharide
D.G. L.			Outifugate i olysaccitatiae
Rotavirus	1	☐ Yes ☐ No	
	2	∐ Yes ∐ No	
	3	」 ∐ Yes ∐ No	
		1 🗖 🗖	Mark one box for each vaccine dose
MMR	1	∐ Yes ∐ No	☐ MMR ☐ Measles only ☐ MMR-Varicella
	2	」	☐ MMR ☐ Measles only ☐ MMR-Varicella
			Mark one box for each vaccine dose
Varicella	1	∐ Yes ∐ No	☐ Varicella only ☐ MMR-Varicella
	2	」 ☐ Yes ☐ No	☐ Varicella only ☐ MMR-Varicella
Hepatitis A	1	Yes No	Diago vomombou to anguer all avections on nove 4
	2	Yes No	Please remember to answer all questions on page 1.
	<u> </u>	100 _ 110	Injected flu vaccines (e.g., Fluzone) Inhaled nasal flu spray (e.g., FluMist)
Influenza	1	☐ Yes ☐ No	☐ TIV ☐ LAIV
	2	Yes No	☐ TIV ☐ LAIV
	3		
		J ∐ Yes ∐ No	☐ TIV ☐ LAIV
	4	」	☐ TIV ☐ LAIV
Other	1	∐ Yes ∐ No ¹	Please enter a
	2	Yes No	description of each vaccine
	3	Yes No -	dose.
	If you need more s	space to report v	vaccines, please attach additional sheets.

# 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 <a href="https://www.cdc.gov/vaccines">www.cdc.gov/vaccines</a>.

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

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-74, 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).

## National Health Interview Provider Survey — Teen Teen Immunization History Questionnaire

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

CDC	
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START HERE Please review your records and complete this questionnaire for the adolescent identified the label to the right. Complete pages 1 and 3 only. Retu the questionnaire in the postage-paid envelope or fax toll to (866) 324-8659. This information is confidential, if faxing please take extra care to dial the correct number.	ırn -free
Which of the following best describes your immunization records for this adolescent?	6. Which of the following best describes this facility?
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.  Please complete item 9 and return form as instructed above.	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 residency 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 Practice 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?	7. Does your practice order vaccines from your state or local health department to administer to children?  No Don't know
First Visit    Month   Day   Year	<ul> <li>8. Did you or your facility report any of this adolescent's immunizations to your community or state registry?  Yes No Don't know Not applicable (No registry in my community/state)</li> <li>9. Contact information for the person returning this</li> </ul>
Most Recent Visit Don't know	form. Name:
4. Did this adolescent receive an 11-12 year old well child exam or check-up at this place?  Yes Don't know	Physician Nurse Office Manager/ Medical Records Receptionist Administrator/Technician Other
5. About how many physicians work at this practice, including those who work part-time?	Phone: ( ) ext.  Fax: ( ) ext.  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 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	Ε		
Vaccine	Date Given			Given by pract			Type of Vaccine	
	<u>Month</u>	<u>Day</u>	<u>Year</u>					
Tetanus boosters	1 11	18	2002	Yes	⊠ No			
MMR	1 9 2	20	2002	Yes Yes	□ No □ No			

- ▶ 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	<b>1</b> 11	20 2001		⊠ Yes	□ No ]	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 Given			Given by other practice?		Type of Vaccine			
	Mont	:h <u>Da</u>	У	<u>Year</u>			Mark one box for each vaccine dose received after age 6			
Td/Tdap boosters	1				Yes	□ No	☐ Td ☐ Tdap (Adacel or Boostrix)			
	2				Yes	☐ No	☐ Td ☐ Tdap (Adacel or Boostrix)			
age 6	3				Yes	☐ No	☐ Td ☐ Tdap (Adacel or Boostrix)			
							HepB only			
Hepatitis B received since	1				Yes	□ No	O.5 ml 1.0 ml Engerix HepB only - HepB-Hib Recombivax Recombivax unknown type			
birth	2				Yes	□No	□ 0.5 ml □ 1.0 ml □ Engerix □ HepB only - □ HepB-Hib Recombivax Recombivax unknown type			
	3				Yes	□ No	0.5 ml 1.0 ml Engerix HepB only - HepB-Hib Recombivax Recombivax unknown type			
	4				Yes	□ No	O.5 ml I.0 ml Engerix HepB only - HepB-Hib Recombivax Recombivax			
							Injected flu vaccines Inhaled nasal flu spray			
Influenza	1				Yes	□ No	Fluzone Fluvirin Other/Unkown Flumist			
received in the past three	2				Yes	□ No	☐ Fluzone ☐ Fluvirin ☐ Other/Unkown ☐ Flumist			
years	3				Yes	□ No	☐ Fluzone ☐ Fluvirin ☐ Other/Unkown ☐ Flumist			
MMR	1		T		Yes	□ No	MMR MMR-Varicella Measles only			
	2				Yes	□ No	☐ MMR ☐ MMR-Varicella ☐ Measles only			
Varicella	1				Yes	□ No	☐ Varicella only ☐ MMR-Varicella			
	2		T		Yes	□ No	☐ Varicella only ☐ MMR-Varicella			
Child ha	as a hist	ory of o	chick	enpox						
Hepatitis A	1				Yes	□ No	HepA only (Havrix or Vaqta)			
	2				Yes	□ No	HepA only (Havrix or Vaqta)			
	3		市		Yes	□ No	HepA only (Havrix or Vaqta)			
Pneumococcal					Yes	□ No				
polysaccharide	2		T		Yes	□ No				
Meningococcal	1				Yes	☐ No	MCV4 (Menactra) MPSV4 (Menomune)			
	2				Yes	□ No	MCV4 (Menactra) MPSV4 (Menomune)			
Human	1				Yes	□No				
papillomavirus	2		寸		Yes	□ No				
(HPV)	3			$\equiv$	Yes	□ No	Please remember to answer all questions on page 1			
							Please enter a description of each vaccine dose			
Other	1				Yes		Please do not			
	2				Yes		record Polio, Hib, or Pneumococcal			
	3				Yes	□ No }	conjugate			
	4				Yes		vaccine (Prevnar) given before 5			
	5				Yes		11			
		If vo	ou ne	ed mor	e space	to report	rt vaccines, please attach additional sheets.			

# Thank you!



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