OMB No. 0920-0214; Approval Expires xx/xx/xxx

National Health Interview Provider Survey
Immunization History Questionnaire

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

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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 toll-free to (866) 324-8659. 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?

- ☐ 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.

Please complete item 9 and return form as instructed above.

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

Month | Day | Year

☐ 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

☐ 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

☐ Don't know

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

☐ 1 ☐ 2 ☐ 3 ☐ 4-6 ☐ 7-10 ☐ 11 or more

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 residency teaching practice.
- ☐ Private practice, including solo, group practice, or HMO.
- ☐ Public health department-operated clinic
- ☐ Military health care facility
- ☐ WIC clinic
- ☐ Other-Explain

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

☐ Yes ☐ No ☐ Don't know

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

☐ Yes ☐ No ☐ Don't know
☐ Not applicable (No registry in my community/state)

9. Contact information for the person returning this form.

Name:

☐ Physician ☐ Nurse
☐ Office Manager/ Receptionist ☐ Medical Records Administrator/Technician
☐ Other

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 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.**

EXAMPLE

Vaccine		Date Given (Month / Day / Year)	Given by other practice	Type of Vaccine (Mark one box for each vaccine dose)
DTP	1	11 / 20 / 2005	☐ Yes ☒ No	☐ DTP ☐ DTaP ☒ DTaP-Hib ☐ DTP-Hib ☐ DTaP-HepB-IPV
	2	11 / 18 / 2006	☒ Yes ☐ No	☐ DTP ☒ DTaP ☐ DTaP-Hib ☐ DTP-Hib ☐ DTaP-HepB-IPV
Hib	1	11 / 20 / 2005	☐ Yes ☒ No	☐ Hib ☐ HepB-Hib ☒ DTaP-Hib ☐ DTP-Hib
	2	11 / 18 / 2006	☒ Yes ☐ No	☒ Hib ☐ HepB-Hib ☐ DTaP-Hib ☐ DTP-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).**

		Month / Day / Year		Mark one box for each vaccine dose
Hepatitis B	1	07 / 19 / 2005	☒ Yes ☐ No	☒ HepB Only ☐ HepB-Hib ☐ DTaP-HepB-IPV
Dose 1 given at birth? ☒ *Yes* ☐ *No*				
	2		☐ Yes ☐ No	☐ 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).**

		Month / Day / Year		Please enter a description of each vaccine dose.
Other	1	11 / 20 / 2006	☐ Yes ☒ No	BCG
	2		☐ Yes ☐ 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 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 (Month / Day / Year)	Given by other practice?	Type of Vaccine
Hepatitis B	1		☐ Yes ☐ No	*Mark one box for each vaccine dose*: ☐ HepB Only ☐ HepB-Hib ☐ DTaP-HepB-IPV
		Dose 1 given at birth? ☐ Yes ☐ No		
	2		☐ Yes ☐ No	☐ HepB Only ☐ HepB-Hib ☐ DTaP-HepB-IPV
	3		☐ Yes ☐ No	☐ HepB Only ☐ HepB-Hib ☐ DTaP-HepB-IPV
	4		☐ Yes ☐ No	☐ HepB Only ☐ HepB-Hib ☐ DTaP-HepB-IPV
DTP	1		☐ Yes ☐ No	*Mark one box for each vaccine dose*: ☐ 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
Hib	1		☐ Yes ☐ No	*Mark one box for each vaccine dose*: ☐ Hib ☐ HepB-Hib ☐ DTaP-Hib ☐ DTP-Hib
	2		☐ Yes ☐ No	☐ Hib ☐ HepB-Hib ☐ DTaP-Hib ☐ DTP-Hib
	3		☐ Yes ☐ No	☐ Hib ☐ HepB-Hib ☐ DTaP-Hib ☐ DTP-Hib
	4		☐ Yes ☐ No	☐ Hib ☐ HepB-Hib ☐ DTaP-Hib ☐ DTP-Hib
	5		☐ Yes ☐ No	☐ Hib ☐ HepB-Hib ☐ DTaP-Hib ☐ DTP-Hib
Polio	1		☐ Yes ☐ No	*Mark one box for each vaccine dose*: ☐ 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
Pneumo-coccal	1		☐ Yes ☐ No	*Mark one box for each vaccine dose*: ☐ Conjugate ☐ Polysaccharide
	2		☐ Yes ☐ No	☐ Conjugate ☐ Polysaccharide
	3		☐ Yes ☐ No	☐ Conjugate ☐ Polysaccharide
	4		☐ Yes ☐ No	☐ Conjugate ☐ Polysaccharide
Rotavirus	1		☐ Yes ☐ No	
	2		☐ Yes ☐ No	
	3		☐ Yes ☐ No	
MMR	1		☐ Yes ☐ No	*Mark one box for each vaccine dose*: ☐ MMR ☐ Measles only ☐ MMR-Varicella
	2		☐ Yes ☐ No	☐ MMR ☐ Measles only ☐ MMR-Varicella
Varicella	1		☐ Yes ☐ No	*Mark one box for each vaccine dose*: ☐ Varicella only ☐ MMR-Varicella
	2		☐ Yes ☐ No	☐ Varicella only ☐ MMR-Varicella
Hepatitis A	1		☐ Yes ☐ No	
	2		☐ Yes ☐ No	
Influenza	1		☐ Yes ☐ No	Injected flu vaccines (e.g., Fluzone): ☐ TIV — Inhaled nasal flu spray (e.g., FluMist): ☐ LAIV
	2		☐ Yes ☐ No	☐ TIV ☐ LAIV
	3		☐ Yes ☐ No	☐ TIV ☐ LAIV
	4		☐ Yes ☐ No	☐ TIV ☐ LAIV
Other	1		☐ Yes ☐ No	Please enter a description of each vaccine dose.
	2		☐ Yes ☐ No	
	3		☐ Yes ☐ No	

Please remember to answer all questions on page 1.

If you need more space to report 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 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.

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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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START HERE → **Please review your records and complete this questionnaire for the adolescent identified on the label to the right. Complete pages 1 and 3 only. Return the questionnaire in the postage-paid envelope or fax toll-free to (866) 324-8659. 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 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.

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

Month ____ Day ____ Year ____ ☐ Don't know

3. What were the dates of this adolescent's first and most recent visit, for any reason, to this place of practice?

	Month	Day	Year	
First Visit				☐ Don't know
Most Recent Visit				☐ Don't know

4. Did this adolescent receive an 11-12 year old well child exam or check-up at this place?

☐ Yes ☐ No ☐ Don't know

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

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4-6 ☐ 7-10 ☐ 11 or more

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 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 _____

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

☐ Yes ☐ No ☐ Don't know

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)

9. Contact information for the person returning this form.

Name: _____

☐ Physician ☐ Nurse
☐ Office Manager/ Receptionist ☐ Medical Records Administrator/Technician
☐ Other

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

Vaccine		Date Given Month	Day	Year	Given by other practice?		Type of Vaccine
Tetanus boosters	1	11	18	2002	☐ Yes	☒ No	
MMR	1	9	20	2002	☒ Yes	☐ No	
	2				☐ Yes	☐ 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	1	11	20	2001	☒ Yes	☐ No	Please do not record Polio, Hib, or Pneumococcal conjugate vaccine (Prevnar) given before 5 years old	*Please enter a description of each vaccine dose* TYPHOID
	2				☐ Yes	☐ 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 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 (Month / Day / Year)	Given by other practice?	Type of Vaccine
Td/Tdap boosters received after age 6	1 / 2 / 3	Yes / No	*Mark one box for each vaccine dose received after age 6*: ☐ Td ☐ Tdap (Adacel or Boostrix)
Hepatitis B received since birth	1 / 2 / 3 / 4	Yes / No	**HepB only**: ☐ 0.5 ml Recombivax ☐ 1.0 ml Recombivax ☐ Engerix ☐ HepB only - unknown type ☐ HepB-Hib
Influenza received in the past three years	1 / 2 / 3	Yes / No	**Injected flu vaccines**: ☐ Fluzone ☐ Fluvirin ☐ Other/Unkown; **Inhaled nasal flu spray**: ☐ Flumist
MMR	1 / 2	Yes / No	☐ MMR ☐ MMR-Varicella ☐ Measles only
Varicella	1 / 2	Yes / No	☐ Varicella only ☐ MMR-Varicella
☐ *Child has a history of chickenpox*			
Hepatitis A	1 / 2 / 3	Yes / No	☐ HepA only (Havrix or Vaqta)
Pneumococcal polysaccharide	1 / 2	Yes / No	
Meningococcal	1 / 2	Yes / No	☐ MCV4 (Menactra) ☐ MPSV4 (Menomune)
Human papillomavirus (HPV)	1 / 2 / 3	Yes / No	
Other	1 / 2 / 3 / 4 / 5	Yes / No	**Please do not record Polio, Hib, or Pneumococcal conjugate vaccine (Prevnar) given before 5 years old**

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.

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.