ARETE PROVIDER NETWORK
Arete Family Medicine - Anchorage

Patient name: _____ Patient DoB: _____

COVID-19 Pre-vaccination Checklist

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "Yes" to any question, it does not necessarily mean you should not be vaccinated**. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Are you feeling sick today?	☐ Yes ☐ No ☐ Don't Know
2. Have you ever received a dose of COVID-19 vaccine?	☐ Yes ☐ No ☐ Don't Know
2a. If Yes, which vaccine product?	☐ Pfizer ☐ Moderna ☐ Another
3. Have you ever had an allergic reaction to something? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital).	☐ Yes ☐ No ☐ Don't Know
3a. If Yes, was it after receiving a component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures?	☐ Yes ☐ No ☐ Don't Know
3b. If Yes, was it after receiving polysorbate?	☐ Yes ☐ No ☐ Don't Know
3C. If Yes, was it after receiving a previous dose of COVID-19 vaccine?	☐ Yes ☐ No ☐ Don't Know
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital).	☐ Yes ☐ No ☐ Don't Know
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.?	☐ Yes ☐ No ☐ Don't Know
6. Have you received any vaccine in the last 14 days?	☐ Yes ☐ No ☐ Don't Know
7. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐ Yes ☐ No ☐ Don't Know
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐ Yes ☐ No ☐ Don't Know
9. Do you have a weakened immune system caused by something such as HIV infection or cancer, or do you take immunosuppressive drugs or therapies?	☐ Yes ☐ No ☐ Don't Know
10. Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes ☐ No ☐ Don't Know
11. Are you pregnant or breastfeeding?	☐ Yes ☐ No ☐ Don't Know

I confirm that I have received a copy of the Fact Sheet for Recipients and Caregivers - Emergency Use Authorization (EUA) of the Moderna COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19) in individuals 18 years of age and older.

_____ _____

Patient signature Date