COVID VACCINATION QUESTIONNAIRE VERSION 22FEB21

PRINT NAME ____

Date of Birth _______________________Age today ______________

NHS number (if known) __________________________________

Phone number _________________________________ Post code _____________

Registered GP Practice: ____

Is this your first or second dose? Please circle: FIRST SECOND

	Yes	No	Unsure
Do you have a fever at the moment?			
Have you ever had a serious allergic reaction?			
Have you ever been prescribed an adrenaline auto-injector such as Epipen?			
Have you been involved in a trial of a covid vaccine?			
Are you taking blood thinning medication?			
Do you have a bleeding disorder?			
Have you had any vaccinations in the past 7 days?			
Have you had a positive covid test in the past 4 weeks?			
Are you pregnant/planning to be pregnant in the next 3 months?			
Are you a carer?			
Are you a healthcare worker?			
Do you work in a residential care home for over 65s?			
Are you registered with a learning disability?			
Are you breastfeeding?			

Circle your ethnic category:

White:	White British	White Irish	Other White	
Mixed:	White/Black Carribean	White/Black African	White/Asian	Other Mixed
Asian / Asian British:	Indian	Pakistani	Bangladeshi	Other Asian
Black / Black British:	Carribean	African	Other Black	
Other:	Chinese	Other		prefer not to say

Common side effects of the vaccine:

Sore arm, feeling tired and achy, headache

Rare side effect:

Serious allergic reaction (please stay in the building for 15 minutes after your vaccination and let a member of staff know if you start to feel unwell)

FOR CLINICIAN USE ONLY: (CIRCLE)

Left / Right Date___________Time___________Clinician_______________________________