Wilkes University

OPTIONAL*

Hepatitis B Vaccination Health History Questionnaire

***ONLY TO BE COMPLETED IF REQUESTING TO RECEIVE HEP B VACCINE**

Last Name:	
First Name:	
WIN #:	
Department:	
Job Title:	
Email Address:	
Today's Date:	
Initial Here:	

1. Have you ever been told that you have Hepatitis B?	**Yes**		**No**	
2. Do you currently have any fever or infections?	**Yes**			
3. Are you currently taking any medications?	**Yes**			
3a. If YES, please list your current medications:				
4. Do you have any chronic heart problems, lung problems, cancer or disease affecting your immunity?	**Yes**		**No**	
4a. If YES, please explain:				
5. Do you have any allergies?	**Yes**		**No**	
5a. If YES, please explain:				

Consent:

I have read the above statements and have been provided with additional information about the Hepatitis B virus vaccine. I am aware that I should ask any questions I may have regarding this vaccine to the medical professionals at University Health Services prior to receive the initial dose of this series. I understand that in my work at Wilkes University I may be at risk of contracting the Hepatitis B virus and that the vaccination has been recommended to prevent my becoming infected or ill. I consent to receive injections of Hepatitis B vaccine and if necessary to have blood drawn following the series.

Signature: Date:

FOR HEALTH SERVICES USE ONLY			
Date Administered	Lot Number	Location	Provider
1.			
2.			
3.			

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