

National Immunization Survey – Teen Teen Immunization History Questionnaire



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

START HERE → Please review your records and complete this questionnaire for the adolescent identified on the label below. 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 items 5-9 and return form as instructed above.

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

Month	Day	Year	
			<input type="checkbox"/> 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				<input type="checkbox"/> Don't know

	Month	Day	Year	
Most Recent Visit				<input type="checkbox"/> 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

5a. Is your practice a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), or a "look alike" FQHC or RHC? Please see Page 4 for definitions.

Yes No Don't know

5b. Which of the following describes this facility?

Check all that apply.

- Private practice (If yes, select Solo, Group, or Health Maintenance Organization (HMO))
- Hospital-based clinic, including university clinic, or residency teaching practice
- Public health department-operated clinic
- Community health center
- Rural Health Clinic
- Migrant health center
- Indian Health Service (IHS)-operated center, Tribal health facility, or urban Indian health care facility
- Military health care facility (Army, Navy, Air Force, Marines, Coast Guard)
- WIC clinic
- School-based health center
- Pharmacy
- Non-medical facility that hosted a vaccination clinic run by the health department or other sponsor
- Other-Explain

5c. 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

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

Yes No Don't know
 Not applicable (Practice does not administer vaccines)

7. 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)
 Not applicable (Practice does not administer vaccines)

8. Contact information for the person returning this form.

Name:

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

Phone: () ext.

Fax: () ext.

9. 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			Given by Other Practice?		Type of Vaccine			
	Month	Day	Year	Yes	No	<i>Mark one box for each vaccine dose received after age 6</i>			
Td/Tdap boosters received after age 6	1	11	18	2002	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap (Adacel® or Boostrix®)	
	2				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap (Adacel® or Boostrix®)	
	3				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap (Adacel® or Boostrix®)	
MMR	1				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> MMR	<input type="checkbox"/> MMR-Varicella	<input type="checkbox"/> Measles only
	2	9	20	2002	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> MMR	<input type="checkbox"/> MMR-Varicella	<input type="checkbox"/> Measles only

- ▶ 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 or additional doses of vaccines listed above	1	11	20	2001	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Please do not record Polio, Hib, or any Pneumococcal vaccine given before 5 years old.	<i>Please enter a description of each vaccine dose</i>	
	2				<input type="checkbox"/> Yes	<input type="checkbox"/> No		TYPHOID	

- ▶ 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

NORC at the University of Chicago
National Immunization Survey – Teen
55 East Monroe Street, 19th Floor
Chicago IL 60603.

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				
	Month	Day	Year			Mark one box for each vaccine dose received after age 6				
Td/Tdap boosters received after age 6	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap (Adacel® or Boostrix®)			
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap (Adacel® or Boostrix®)			
	3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap (Adacel® or Boostrix®)			
Hepatitis B received since birth	HepB only									
	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 0.5 ml Recombivax®	<input type="checkbox"/> 1.0 ml Recombivax®	<input type="checkbox"/> Enderix®	<input type="checkbox"/> HepB only - unknown type	<input type="checkbox"/> HepB-Hib
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 0.5 ml Recombivax®	<input type="checkbox"/> 1.0 ml Recombivax®	<input type="checkbox"/> Enderix®	<input type="checkbox"/> HepB only - unknown type	<input type="checkbox"/> HepB-Hib
	3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 0.5 ml Recombivax®	<input type="checkbox"/> 1.0 ml Recombivax®	<input type="checkbox"/> Enderix®	<input type="checkbox"/> HepB only - unknown type	<input type="checkbox"/> HepB-Hib
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 0.5 ml Recombivax®	<input type="checkbox"/> 1.0 ml Recombivax®	<input type="checkbox"/> Enderix®	<input type="checkbox"/> HepB only - unknown type	<input type="checkbox"/> HepB-Hib	
Seasonal Influenza received in the past three years	Mark one box for each vaccine dose									
	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Inactivated Influenza Vaccine (IIV) ^a		<input type="checkbox"/> Live Attenuated Influenza Vaccine (LAIV) ^b		
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Inactivated Influenza Vaccine (IIV) ^a		<input type="checkbox"/> Live Attenuated Influenza Vaccine (LAIV) ^b		
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Inactivated Influenza Vaccine (IIV) ^a		<input type="checkbox"/> Live Attenuated Influenza Vaccine (LAIV) ^b			
^a Injected, eg. Fluzone®, Fluvirin®, Fluarix®, Afluria®, FluLaval®, Flucelvax® ^b Inhaled nasal flu spray, eg. FluMist®										
MMR	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MMR	<input type="checkbox"/> MMR-Varicella	<input type="checkbox"/> Measles only		
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MMR	<input type="checkbox"/> MMR-Varicella	<input type="checkbox"/> Measles only		
Varicella	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Varicella only	<input type="checkbox"/> MMR-Varicella			
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Varicella only	<input type="checkbox"/> MMR-Varicella			
<input type="checkbox"/> Child has a history of chickenpox										
Hepatitis A	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> HepA only (Havrix® or Vaqta®)				
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> HepA only (Havrix® or Vaqta®)				
	3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> HepA only (Havrix® or Vaqta®)				
Meningococcal - serogroups ACWY	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MCV4 or MenACWY (Menactra®, Menveo® or MenQuadfi®)		<input type="checkbox"/> MPSV4 (Menomune®)		
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MCV4 or MenACWY (Menactra®, Menveo® or MenQuadfi®)		<input type="checkbox"/> MPSV4 (Menomune®)		
Meningococcal - serogroup B	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MenB-FHbp (Trumenba®)		<input type="checkbox"/> MenB-4C (Bexsero®)		
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MenB-FHbp (Trumenba®)		<input type="checkbox"/> MenB-4C (Bexsero®)		
	3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MenB-FHbp (Trumenba®)		<input type="checkbox"/> MenB-4C (Bexsero®)		
Human papillomavirus (HPV)	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Gardasil® (4vHPV)	<input type="checkbox"/> Gardasil® 9 (9vHPV)	<input type="checkbox"/> Cervarix® (2vHPV)		
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Gardasil® (4vHPV)	<input type="checkbox"/> Gardasil® 9 (9vHPV)	<input type="checkbox"/> Cervarix® (2vHPV)		
	3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Gardasil® (4vHPV)	<input type="checkbox"/> Gardasil® 9 (9vHPV)	<input type="checkbox"/> Cervarix® (2vHPV)		
COVID-19 Vaccine	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pfizer-BioNTech®	<input type="checkbox"/> Moderna®	<input type="checkbox"/> Janssen-Johnson & Johnson®		
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pfizer-BioNTech®	<input type="checkbox"/> Moderna®			
Other or additional doses of vaccines listed above	Please enter a description of each vaccine dose									
	1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<div style="font-size: 3em;">}</div> Please do not record Polio, Hib, or any Pneumococcal vaccine given before 5 years old.	<input type="text"/>			
	2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="text"/>			
	3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="text"/>			
	4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="text"/>			
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>					

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, please visit the CDC Vaccines & Immunization website at www.cdc.gov/vaccines.

If you would like more information about the National Immunization Survey, including data and statistics from previous years, please visit the National Immunization Survey website at <http://www.cdc.gov/vaccines/NIS>. If you have any questions or comments about this study, please call (800) 817 4316 or email nis@cdc.gov.

If you would prefer the study team to send immunization history requests via encrypted email, please reach out to us at NISProvider@norc.org.

Note: Do NOT send any confidential patient information, such as patient's name or date of birth, in an email message.

Definitions:

Federally Qualified Health Center (FQHC): A Federally Qualified Health Center as defined under section 1905(l)(2) of the Social Security Act. FQHCs receive grants under Section 330 of the Public Health Service Act. (B) The term "Federally-qualified health center" means an entity which:
(i) is receiving a grant under section 330 of the Public Health Service Act[282],
(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and
(II) meets the requirements to receive a grant under section 330 of such Act.

Rural Health Clinic (RHC): A Rural Health Clinic as defined under section 1905(l)(1) of the Social Security Act. A Rural Health Clinic (RHC) is a clinic certified to receive special Medicare and Medicaid reimbursement.

FQHC Look-Alike: An organization that meets all of the eligibility requirements of an organization that receives a PHS Section 330 grant, but does not receive grant funding.