CHINESE GENERAL HOSPITAL AND MEDICAL CENTER
COVID-19 VACCINATION CHART

GENERAL INFORMATION			
LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

AGE:	BIRTHDAY:
ADDRESS:	
CONTACT NUMBER:	EMAIL ADDRESS:

ALLERGY RISK ASSESSMENT	
1st visit	2nd visit
☐	☐ History of allergic diseases or previous severe general reactions treated by a physician.
☐	☐ Allergic reactions to food, inhalant environmental allergens, insects, latex, oral medications, not related to vaccines and of their components.
☐	☐ Well-controlled asthma, allergic rhinitis on intranasal corticosteroids
☐	☐ Immunodeficiency or Autoimmune disease (e.g. Guillain-Barre Syndrome, Bell's Palsy)
☐	☐ Uncontrolled asthma or mast cell disordersImmediate (within 4 hours) allergic reaction, such as, urticaria, angioedema, difficulty of breathing, to any OTHER vaccine or injected therapy
☐	☐ Immediate (within 4 hours) allergic reaction, whether mild (e.g. rashes) or severe (e.g. anaphylaxis) to COVID-19 vaccine after the first dose
☐	☐ Allergic reaction or anaphylaxis (within 4 hours) to any COVID-19 vaccine excipients such as polyethylene glycol (PEG) also found in colonoscopy preparation or laxatives; or to polysorbate also found in vascular graft materials, surgical gels, regulated medications.
☐	☐ None of the above

HISTORY OF COVID-19 INFECTION
☐ History of previous COVID-19 infection. Date diagnosed: _____
☐ Severity (encircle: asymptomatic, mild, moderate, severe)
☐ Received monoclonal antibodies (e.g. tocilizumab). Date given: _____
☐ Received convalescent plasma. Date given: _____
☐ None of the above

PAST MEDICAL HISTORY	
☐ Hypertension	☐ Tuberculosis
☐ Heart Disease	☐ Steroid Use
☐ Diabetes Mellitus	☐ Blood Recipient Date: _____
☐ Kidney Disease	For Women:
☐ On Dialysis	☐ Last Menstrual Period Date: _____
☐ Cancer	
☐ Immunodeficient state	☐ Breastfeeding

REVIEW OF SYSTEMS (write “none” if no complaints)		
	Visit 1	Visit 2
General		
HEENT		
Respiratory		
Cardiac		
Gastrointestinal		
Musculoskeletal		
Neurologic		
Others		

PHYSICAL EXAM

Visit 1 BP: _____ HR: _____ RR: _____ O2 Sat: _____ Temperature: _____
Visit 2 BP: _____ HR: _____ RR: _____ O2 Sat: _____ Temperature: _____

PHYSICAL EXAM FINDINGS (check if normal)			
	Visit 1	Visit 2	
	Normal	Normal	Specific Findings if Abnormal
General			
HEENT			
Lungs			
Heart			
Abdomen			
Extremities			
Neurologic			
Others			

COVID-19 Vaccine Risk Assessment

☐ May receive COVID-19 Vaccine without further work up (Visit 1)
☐ May receive COVID-19 Vaccine without further work up (Visit 2)
☐ Delay vaccination. Date: _____ Reason: _____
☐ Needs clearance from specialist prior to vaccination. Specify: _____
☐ COVID-19 Vaccination Contraindicated. Reason: _____

SCREENED BY:	
First visit	Second visit
Signature over printed name	Signature over printed name
Date	Date

VACCINE GIVEN					
	Product Name/ Manufacturer	Lot/Batch No.	Expiry Date	Date given	Given by
1st dose					
2nd dose					

POST VACCINATION MONITORING	
DATE/TIME	
	☐ NO REMARKABLE EVENTS AFTER 30 MINUTES OBSERVATION (1st dose)
	☐ NO REMARKABLE EVENTS AFTER 30 MINUTES OBSERVATION (2nd dose)
	Others:

MONITORING CONFIRMED BY:	
First visit	Second visit
Signature over printed name	Signature over printed name
Date	Date