# National Immunization Survey
## Immunization History Questionnaire

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

CDC SAFER·HEALTHIER·PEOPLE™

**START HERE** → **Please review your records and complete this questionnaire for the child identified on the label below. 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 child?**

- ☐ You have all or partial immunization records for this child, for vaccines given by your practice or other practices.
  - → Was any of the immunization information for this child obtained from your community or state registry?
    - ☐ Yes ☐ No ☐ Don't Know

  Go to question 2 below.
- ☐ This facility gives immunizations only at birth (hospital). Go to question 2 below.
- ☐ Other-Explain
- ☐ You have provided care to this child, but do not have immunization records.
- ☐ You have no record of providing care to this child.

**Please complete items 5-9 and return form as instructed above.**

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

Month | Day | Year

☐ Don't know

**3. What was the date of this child's *first* visit, for any reason, to this place of practice?**

Month | Day | Year

☐ Don't know

**4. What was the date of this child's *most recent* visit, for any reason, to this place of practice?**

Month | Day | Year

☐ 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
- ☐ 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 child'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 on the insert provided. Then complete the Shot Grid on pages 2 and 3.

**Refer to your vaccination records for the child named on the labels on the front cover and next page of this form. Mark the boxes for the correct combination vaccine for each dose. For example, if the combination vaccine included both DTaP and Hib, be sure to enter information in both DTaP and Hib vaccine categories. For examples, see the instruction insert provided.**

▶ **After completing the Shot Grid, please return this form in the envelope provided.**

**(Optional) You may also attach a copy of your immunization history records for this child to this form and send it back to**

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

**If you choose this option, please answer all questions on page 1.**

**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 through 3.**

# START HERE

| Vaccine | Date Given (Month / Day / Year) | Given by other practice? | Type of Vaccine |
|---|---|---|---|
| **Hepatitis B** | | | *Mark one box for each vaccine dose* |
| 1 | | ☐ Yes ☐ No | ☐ HepB Only ☐ DTaP-HepB-IPV[a] ☐ DTaP-IPV-Hib-HepB[b] |
| *Dose 1 given at birth?* ☐ *Yes* ☐ *No* | | | |
| 2 | | ☐ Yes ☐ No | ☐ HepB Only ☐ DTaP-HepB-IPV[a] ☐ DTaP-IPV-Hib-HepB[b] |
| 3 | | ☐ Yes ☐ No | ☐ HepB Only ☐ DTaP-HepB-IPV[a] ☐ DTaP-IPV-Hib-HepB[b] |
| 4 | | ☐ Yes ☐ No | ☐ HepB Only ☐ DTaP-HepB-IPV[a] ☐ DTaP-IPV-Hib-HepB[b] |
| | | | [a]Pediarix® [b]Vaxelis® |
| **DTaP** | | | *Mark one box for each vaccine dose* |
| 1 | | ☐ Yes ☐ No | ☐ DTaP/DTP ☐ DTaP-HepB-IPV[a] ☐ DTaP-IPV-Hib[b] ☐ DTaP-IPV-Hib-HepB[c] |
| 2 | | ☐ Yes ☐ No | ☐ DTaP/DTP ☐ DTaP-HepB-IPV[a] ☐ DTaP-IPV-Hib[b] ☐ DTaP-IPV-Hib-HepB[c] |
| 3 | | ☐ Yes ☐ No | ☐ DTaP/DTP ☐ DTaP-HepB-IPV[a] ☐ DTaP-IPV-Hib[b] ☐ DTaP-IPV-Hib-HepB[c] |
| 4 | | ☐ Yes ☐ No | ☐ DTaP/DTP ☐ DTaP-HepB-IPV[a] ☐ DTaP-IPV-Hib[b] ☐ DTaP-IPV-Hib-HepB[c] |
| 5 | | ☐ Yes ☐ No | ☐ DTaP/DTP ☐ DTaP-HepB-IPV[a] ☐ DTaP-IPV-Hib[b] ☐ DTaP-IPV-Hib-HepB[c] |
| | | | [a]Pediarix® [b]Pentacel® [c]Vaxelis® |
| **Hib** | | | *Mark one box for each vaccine dose* |
| 1 | | ☐ Yes ☐ No | ☐ Merck[a] ☐ Sanofi[b] ☐ DTaP-Hib ☐ DTaP-IPV-Hib[c] ☐ HibMenCY ☐ DTaP-IPV-Hib-HepB[d] |
| 2 | | ☐ Yes ☐ No | ☐ Merck[a] ☐ Sanofi[b] ☐ DTaP-Hib ☐ DTaP-IPV-Hib[c] ☐ HibMenCY ☐ DTaP-IPV-Hib-HepB[d] |
| 3 | | ☐ Yes ☐ No | ☐ Merck[a] ☐ Sanofi[b] ☐ DTaP-Hib ☐ DTaP-IPV-Hib[c] ☐ HibMenCY ☐ DTaP-IPV-Hib-HepB[d] |
| 4 | | ☐ Yes ☐ No | ☐ Merck[a] ☐ Sanofi[b] ☐ DTaP-Hib ☐ DTaP-IPV-Hib[c] ☐ HibMenCY ☐ DTaP-IPV-Hib-HepB[d] |
| 5 | | ☐ Yes ☐ No | ☐ Merck[a] ☐ Sanofi[b] ☐ DTaP-Hib ☐ DTaP-IPV-Hib[c] ☐ HibMenCY ☐ DTaP-IPV-Hib-HepB[d] |
| | | | [a]PedvaxHIB®, PRP-OMP [b]ActHIB®, PRP-T [c]Pentacel® [d]Vaxelis® |
| **Polio** | | | *Mark one box for each vaccine dose* |
| 1 | | ☐ Yes ☐ No | ☐ IPV ☐ DTaP-HepB-IPV[a] ☐ DTaP-IPV-Hib[b] ☐ OPV ☐ DTaP-IPV-Hib-HepB[c] |
| 2 | | ☐ Yes ☐ No | ☐ IPV ☐ DTaP-HepB-IPV[a] ☐ DTaP-IPV-Hib[b] ☐ OPV ☐ DTaP-IPV-Hib-HepB[c] |
| 3 | | ☐ Yes ☐ No | ☐ IPV ☐ DTaP-HepB-IPV[a] ☐ DTaP-IPV-Hib[b] ☐ OPV ☐ DTaP-IPV-Hib-HepB[c] |
| 4 | | ☐ Yes ☐ No | ☐ IPV ☐ DTaP-HepB-IPV[a] ☐ DTaP-IPV-Hib[b] ☐ OPV ☐ DTaP-IPV-Hib-HepB[c] |
| | | | [a]Pediarix® [b]Pentacel® [c]Vaxelis® |

| Vaccine | Date Given (Month / Day / Year) | Given by other practice? | Type of Vaccine |
|---|---|---|---|
| **Pneumococcal** | 1 | ☐ Yes ☐ No | ***Mark one box for each vaccine dose*** ☐ Conjugate-7[a] ☐ Conjugate-13[b] ☐ Polysaccharide[c] ☐ Conjugate-15[d] ☐ Conjugate-20[e] |
| | 2 | ☐ Yes ☐ No | ☐ Conjugate-7[a] ☐ Conjugate-13[b] ☐ Polysaccharide[c] ☐ Conjugate-15[d] ☐ Conjugate-20[e] |
| | 3 | ☐ Yes ☐ No | ☐ Conjugate-7[a] ☐ Conjugate-13[b] ☐ Polysaccharide[c] ☐ Conjugate-15[d] ☐ Conjugate-20[e] |
| | 4 | ☐ Yes ☐ No | ☐ Conjugate-7[a] ☐ Conjugate-13[b] ☐ Polysaccharide[c] ☐ Conjugate-15[d] ☐ Conjugate-20[e] |
| | 5 | ☐ Yes ☐ No | ☐ Conjugate-7[a] ☐ Conjugate-13[b] ☐ Polysaccharide[c] ☐ Conjugate-15[d] ☐ Conjugate-20[e] |
| | 6 | ☐ Yes ☐ No | ☐ Conjugate-7[a] ☐ Conjugate-13[b] ☐ Polysaccharide[c] ☐ Conjugate-15[d] ☐ Conjugate-20[e] |
| | | | [a]Prevnar® (PCV7) [b]Prevnar13® (PCV13) [c]Pneumovax® (PPSV23) [d]Vaxneuvance™ (PCV15) [e]Prevnar20® (PCV20) |
| **Rotavirus (RV)** | 1 | ☐ Yes ☐ No | ***Mark one box for each vaccine dose*** ☐ RotaTeq® – Merck (RV5) ☐ Rotarix® – GSK (RV1) |
| | 2 | ☐ Yes ☐ No | ☐ RotaTeq® – Merck (RV5) ☐ Rotarix® – GSK (RV1) |
| | 3 | ☐ Yes ☐ No | ☐ RotaTeq® – Merck (RV5) ☐ Rotarix® – GSK (RV1) |
| **MMR** | 1 | ☐ Yes ☐ No | ***Mark one box for each vaccine dose*** ☐ MMR ☐ Measles only ☐ MMR-Varicella |
| | 2 | ☐ Yes ☐ No | ☐ MMR ☐ Measles only ☐ MMR-Varicella |
| **Varicella** | 1 | ☐ Yes ☐ No | ***Mark one box for each vaccine dose*** ☐ Varicella only ☐ MMR-Varicella ☐ ***Child has a history of chickenpox*** |
| | 2 | ☐ Yes ☐ No | ☐ Varicella only ☐ MMR-Varicella |
| **Hepatitis A** | 1 | ☐ Yes ☐ No | ***Please remember to answer all questions on page 1.*** |
| | 2 | ☐ Yes ☐ No | |
| **Seasonal Influenza** | 1 | ☐ Yes ☐ No | ***Mark one box for each vaccine dose*** ☐ Inactivated Influenza Vaccine (IIV)[a] ☐ Live Attenuated Influenza Vaccine (LAIV)[b] |
| | 2 | ☐ Yes ☐ No | ☐ Inactivated Influenza Vaccine (IIV)[a] ☐ Live Attenuated Influenza Vaccine (LAIV)[b] |
| | 3 | ☐ Yes ☐ No | ☐ Inactivated Influenza Vaccine (IIV)[a] ☐ Live Attenuated Influenza Vaccine (LAIV)[b] |
| | 4 | ☐ Yes ☐ No | ☐ Inactivated Influenza Vaccine (IIV)[a] ☐ Live Attenuated Influenza Vaccine (LAIV)[b] |
| | | | [a]Injected, eg. Fluzone®, Fluarix®, FluLaval® [b]Inhaled nasal flu spray, eg. FluMist® |
| **COVID-19 Vaccine** | 1 | ☐ Yes ☐ No | ***Mark one box for each vaccine dose*** ☐ Pfizer-BioNTech® ☐ Moderna® ☐ OTHER COVID-19 Vaccine → ***Please specify brand*** |
| | 2 | ☐ Yes ☐ No | ☐ Pfizer-BioNTech® ☐ Moderna® ☐ OTHER COVID-19 Vaccine → |
| | 3 | ☐ Yes ☐ No | ☐ Pfizer-BioNTech® ☐ Moderna® ☐ OTHER COVID-19 Vaccine → |
| | 4 | ☐ Yes ☐ No | ☐ Pfizer-BioNTech® ☐ Moderna® ☐ OTHER COVID-19 Vaccine → |
| **Other** | 1 | ☐ Yes ☐ No | **Please enter a description of each vaccine dose.** |
| | 2 | ☐ Yes ☐ No | |
| | 3 | ☐ Yes ☐ No | |

***If you need more space to report vaccines, please attach additional sheets.***

| Data Coll Period | Initial | Date |
|---|---|---|
| Progress | | |
| MR or QX rcvd | | |
| Trans complete | | |
| Need Retrieval | | |
| Retrieval Complete | | |
| Edit Complete | | |
| DE Vndr return | | |

# 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.