Occupational and Community Health Services, Inc.
3300 Hudson Ave, Union City, NJ 07087 Tel. (201)325-8002 Fax. (201)325-9718
www.mymobileclinic.org

First name	Last name	Date of birth (MM/DD/YY)	ID/Passport #	Telephone #
Address	**Apartment #**	**City**	**State**	**Zip code**
Country of origin	**Medical insurance name**	**Medical insurance #**	**Group #**	**Payer ID**
Hispanic ◯	**Asian** ◯	**African-American** ◯	**Caucasian** ◯	**Other race** ◯

Questions prior to vaccination:

1. Do you feel sick **today**?.....Yes ◯ No ◯
2. **In the last 30 days, have you had:**
   Cough, fever, phlegm, malaise, diarrhea, chest pain, shortness of breath?.....Yes ◯ No ◯
   Have you been exposed to someone with a cold or COVID?..... Yes ◯ No ◯
   Have you tested positive for COVID?..... Yes ◯ No ◯
3. **In the last 3 months:**
   Have you received treatment with monoclonal antibodies for COVID?.....Yes ◯ No ◯
   Have you had a previous COVID-19 vaccine? .....Yes ◯ No ◯
   Which vaccine?_____ When?_____
4. **Circle yes for all that apply to you:**
   Cancer?..... Yes ◯ No ◯
   Have received chemotherapy?.....Yes ◯ No ◯
   Have a disorder of the blood, platelets or a tendency to bleed?.....Yes ◯ No ◯
   Have a weakened immune system (ex. HIV/AIDs)?.....Yes ◯ No ◯
   Intolerance or bleeding with herparin?.....Yes ◯ No ◯
   Allergies to injectable therapies? .....Yes ◯ No ◯
   Allergies to medications? .....Yes ◯ No ◯
   Allergies to vaccines?.....Yes ◯ No ◯
   Alergies a polyethylene glycol (PEG), laxatives, preparations for colonoscopy?.....Yes ◯ No ◯
   Have received dermal fillers?.....Yes ◯ No ◯
   Diagnosed with Multisystem Inflammatory Syndrome (MIS)?..... .....Yes ◯ No ◯
   Please list any allergies and degree of allergic reaction:
   _____
5. **At this time, do you take any of these medications:**
   Anticoagulants, aspirin, coumadin (Warfarin)?..... Yes ◯ No ◯
   Cancer medicagtions?.....Yes ◯ No ◯
   Transplant medications?.....Yes ◯ No ◯
6. **Why haven't you been vaccinated?** _____
7. **Who/what convinced you to get vaccinated**? _____
8. **Who still hasn't gotten vaccinated in your family/job?** _____
9. **Women only:** Are you pregnant or breastfeeding?.....Yes ◯ No ◯

For medical provider/nurse or pharmacist only ×Pfizer EUA fact sheet provided
Covid-19 vaccine, Pfizer 0.3 ml, Lot _____ Exp___ Vaccine #1 #2
Administration deltoid site: Left Right Date_____ Place/City:_____
Name of vaccine administrator: _____RN/MD/Rph Signature:_____