Universität Zürich[UZH]

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Patient Intake Form for the COVID-19 Vaccination

Please carefully read and complete this form.

First Name	
Date of Birth	
Today`s Date	

Last Name	
6-Digit VacMe Code	

Please indicate which dose you are receiving: ☐ 1st dose ☐ 2nd dose

Potential Contraindications		
Do you currently have a fever or cold symptoms (sore throat, cough, body aches, headache, loss of taste or smell)? *If yes, then please be tested for COVID-19 and book an appointment to receive your vaccine at a later date.*	☐ YES	☐ NO
Were you diagnosed with COVID-19 in the past? *If so, then please make sure your vaccination appointment is at least 90 days after your COVID-19 diagnosis.*	☐ YES	☐ NO
Do you have any allergies (such as to medications or to previous vaccinations or food)? *If so, which one?* _____	☐ YES	☐ NO
Have you had a problem with a previous vaccination? *If so, which one?* _____	☐ YES	☐ NO
Have you received a non-COVID vaccination in the last 7 days?	☐ YES	☐ NO
Are you taking anticoagulants ("blood thinners") or do you have a medical condition that makes you more likely to bleed? *If so, which one?* _____	☐ YES	☐ NO

For Women		
Are you currently pregnant or is there a possibility that you might be pregnant?	☐ YES	☐ NO