Patient history for vaccination against COVID-19 with an mRNA vaccine: BIONTECH® (Comirnaty®) or MODERNA® (Spikevax®)

Have you already been reliably diagnosed as infected with COVID-19? Yes ☐ No ☐

If so, when and how? _____

Have you already been vaccinated against COVID-19? If with what? Yes ☐ No ☐

1st Date: _____ 1. Vaccine: _____

2nd Date: _____ 2. Vaccine: _____

3rd date: _____ 3. Vaccine: _____

Did you have an allergic reaction to your last COVID-19 vaccination? Yes ☐ No ☐

Have you ever **lost consciousness** during a vaccination? Yes ☐ No ☐

Do you currently have an acute illness with fever? Yes ☐ No ☐

Could you currently be pregnant? Are you breastfeeding? (Women only) Yes ☐ No ☐

Do you have any known allergies? If yes, to what? Yes ☐ No ☐

_____

Do you have a primary care physician? If yes, please specify: _____ Yes ☐ No ☐

Do you have any of the following conditions/diagnoses?

☐ Depression	☐ Diabetes mellitus	☐ Migraine
☐ Asthma	☐ Heart disease	☐ Autoimmune disease
☐ Thyroid disease	☐ Tumor disease	☐ Gynecological disease
☐ High blood pressure	☐ Thromboses	☐ Stroke

☐ Other: _____

Are you taking any medication? If yes, which ones?

_____

Please turn

Informed consent for vaccination against COVID-19 with an mRNA vaccine: BIONTECH® (Comirnaty®) or MODERNA® (Spikevax®)

PLEASE FILL IN IN BLOCK CAPITALS.

Name: _____ First Name: _____

Date of Birth: _____

Address: _____ Zip code, city: _____

Email: _____ Telephone :_____

Please mark with a cross where applicable:

- ☐ I consent to the proposed vaccination against COVID-19, have read the currently valid educational information and have had the opportunity for a detailed discussion with a vaccinator.
- ☐ I consent to the proposed vaccination, expressly waive the medical information session, have no further questions and have taken note of the currently applicable educational information.

To be completed by the doctor:	To be completed by the person to be vaccinated or the legal representative:
Signature, stamp: _____	Place, date: Berlin _____ Signature: _____

If the person to be vaccinated is not capable of giving consent, the consent to vaccination or the refusal of vaccination is given by the legal representative.

To be completed by the legal representative:

Name: _____ First Name: _____

Date of Birth: _____

Address: _____ Zip code, city: _____

Email: _____ Telephone:_____

Please turn