SOUTHEAST OBSTETRICS AND GYNECOLOGY, PC

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PATIENT INFORMATION:

DATE OF VISIT:_____

PATIENT NAME: _____ BIRTH DATE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
SOCIAL SECURITY #_____ MARITAL STATUS _____
HOME PHONE: _____ CELL PHONE: _____
RACE: _____ ETHNICITY: _____ LANGUAGE: _____
E-MAIL: _____ EMPLOYER: _____
WORK PHONE: _____ OCCUPATION: _____
MAY WE CONTACT YOU AT ALL THE NUMBERS ABOVE? YES____ NO ____
IF NO PLEASE SPECIFY WHERE WE CANNOT CONTACT YOU: _____
SPOUSE NAME: _____ PHONE: _____
EMERGENCY CONTACT: _____ RELATIONSHIP: _____
FAMILY DOCTOR NAME: _____
REFERRING DOCTOR: _____ OB/GYN: _____

INSURANCE INFORMATION:

INSURANCE COMPANY: _____ EFFECTIVE DATE: _____
POLICY NUMBER: _____ INS CO. PHONE: _____
ADDRESS: _____
SUBSCRIBER NAME: _____ DATE OF BIRTH: _____
SOCIAL SECURITY: _____ RELATIONSHIP TO PATIENT: _____

PERSON RESPONSIBLE FOR PAYMENT (if other than patient):

NAME: _____ DATE OF BIRTH: _____ SS#: _____
ADDRESS: _____
PHONE: _____ CELL: _____ WORK: _____
EMPLOYER: _____ OCCUPATION: _____
ADDRESS: _____ RELATIONSHIP TO PATIENT: _____

PHOTO ID CHECKED ____ DATE: _____ INITIALS _____

PLEASE TURN OVER

SOUTHEAST OBSTETRICS AND GYNECOLOGY, P.C.
CONFIDENTIAL PATIENT HISTORY

(Rev. 10/09)

The information on this form is intended to help the physician with your diagnosis and treatment. Please complete both sides of the form as fully as possible.

Name_____ Phone #_____ Date_____

Birth Date_____ Age_____ Marital Status: S M Sep W D

Primary Care Provider_____ PCP Office Location_____

FAMILY HISTORY:

☐ No ☐ Yes Are you adopted?

Has anyone in your family had the following: Include Mother (M), Father (F), Brother (B), Sister (S) Grandfather (MGF or PGF - Maternal or Paternal), Grandmother (MGM or MGF - Maternal or Paternal)

No	Yes		Who	No	Yes		Who	No	Yes		Who
☐	☐	Diabetes		☐	☐	High cholesterol		☐	☐	Breast cancer	
☐	☐	Heart disease		☐	☐	Thyroid disease		☐	☐	Ovarian cancer	
☐	☐	Lung disease		☐	☐	Osteoporosis		☐	☐	Uterine cancer	
☐	☐	Depression		☐	☐	Sickle-Cell disease		☐	☐	Cervical cancer	
☐	☐	High blood pressure		☐	☐	Arthritis		☐	☐	Colon cancer	
☐	☐	Stroke		☐	☐	Other hereditary diseases		☐	☐	Other cancers	

MEDICAL HISTORY/REVIEW OF SYSTEMS:

Do you have, or have you ever had, any of the following:

Yes	Now		No	Yes	Now		No	Yes	Now	
☐	☐	Weight gain/loss >10 lbs	☐	☐	☐	Breast disease	☐	☐	☐	Kidney problem
☐	☐	Marked fatigue	☐	☐	☐	Diabetes	☐	☐	☐	Bladder infection
☐	☐	Hearing loss	☐	☐	☐	Thyroid problem	☐	☐	☐	Stomach/bowel problem
☐	☐	Sinus problems	☐	☐	☐	Depression/anxiety	☐	☐	☐	Liver disease
☐	☐	Heart disease	☐	☐	☐	Numbness or tingling of extremities	☐	☐	☐	Shortness of breath
☐	☐	Lung disease					☐	☐	☐	Arthritis
☐	☐	Chest pain	☐	☐	☐	Epilepsy/seizures	☐	☐	☐	Toxic work exposure
☐	☐	Palpitations	☐	☐	☐	Stroke	☐	☐	☐	Skin problems
☐	☐	High blood pressure	☐	☐	☐	Headaches	☐	☐	☐	Asthma
☐	☐	Varicose veins	☐	☐	☐	Difficulty swallowing	☐	☐	☐	Blood clots
☐	☐	Anemia	☐	☐	☐	Bleeding disorders	☐	☐	☐	Other illness (list type)
☐	☐	Cancer, Type_____	☐	☐	☐	Osteoporosis				

MEDICATIONS

Please list all medications you are using by name and dosage (include vitamins and herbs)

_____

_____

_____

_____

_____

Birth control_____

ALLERGIES

Are you allergic to (circle): Latex Iodine/Shellfish

Allergies to medications: Please list drug and reaction:

_____

_____

_____

_____

_____

_____

SURGICAL/HOSPITALIZATION HISTORY

Please list the date and type of surgery or reason for hospitalization:

Date	Type	Date	Type

SOUTHEAST OBSTETRICS AND GYNECOLOGY, P.C.
CONFIDENTIAL PATIENT HISTORY

(Rev. 09/09)

Name_____ DOB_____

PREGNANCY HISTORY

Date of Pregnancies (date of delivery, loss, or termination)	Type of Delivery (vaginal/c-section/loss)	Complications	Sex

GYN/MENSTRUAL HISTORY

Age period started_____ LMP_____
Periods come every_____days and last for_____ days
Periods are: ☐ regular ☐ irregular ☐ light ☐ moderate ☐ heavy

☐ No ☐ Yes Are you sexually active? Your partner is: ☐ Male ☐ Female

Do you have now, or have you ever had problems with the following:

No Yes Now
- ☐ ☐ ☐ Severe cramps with your period
- ☐ ☐ ☐ Bleeding between periods
- ☐ ☐ ☐ Vaginal discharge/infection
- ☐ ☐ ☐ STD (sexually transmitted disease):
  - ☐ syphilis ☐ gonorrhea ☐ trichomonas
  - ☐ chlamydia ☐ herpes ☐ genital warts ☐ HIV
- ☐ ☐ ☐ Abnormal Pap smears
- ☐ ☐ ☐ Abnormalities of the uterus
- ☐ ☐ ☐ Tumors/cysts of ovaries
- ☐ ☐ ☐ Infertility/Endometriosis
- ☐ ☐ ☐ Sexual difficulty
- ☐ ☐ ☐ Pain/bleeding with intercourse
- ☐ ☐ ☐ Bothersome loss of urine

WELLNESS/SCREENING

	Date of last test/immunization:
Pap smear	
Mammogram	
Bone density	
Cholesterol	
Colonoscopy or Sigmoidoscopy	
Fecal Occult Blood cards	
Tetanus shot	
Pneumonia Vaccine	

☐ No ☐ Yes Do you have a health care proxy?
☐ No ☐ Yes Do you perform self breast exams monthly?
☐ No ☐ Yes Do you exercise? Type & frequency:_____

☐ No ☐ Yes Do you get enough calcium (1200 mg)?
☐ No ☐ Yes Do you always wear your seat belt?
☐ No ☐ Yes Are you current with dental care?
☐ No ☐ Yes Are you on any particular diet?
☐ No ☐ Yes 3 Gardasil Vaccinations completed (if < age 27?

SOCIAL HISTORY

Circle the highest year of school completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 >17 Degree_____

Occupation_____Employer_____

- ☐ ☐ Yes ☐ Caffeine: Average amount /day_____
- ☐ ☐ Yes ☐ Tobacco: If Yes, _____packs/day for how many years_____
- No ☐ Yes ☐ Street drugs: what?_____
- No ☐ Yes ☐ Alcohol: # drinks per day (beer, wine, liquor)_____
- No ☐ Yes ☐ History of physical or sexual abuse?

TODAY'S VISIT

What concerns or problems would you like to discuss today?

_____

_____

Are you interested in?:
- No ☐ Yes ☐ HIV (AIDS) testing?
- No ☐ Yes ☐ Other STD testing?
- No ☐ Yes ☐ Chaperone with exam

Patient's Signature_____ Date_____

OFFICE USE ONLY:
I have reviewed the above and personally discussed this with the patient._____ MD Date_____

SOUTHEAST OB/GYN, ESTABLISHED ANNUAL HISTORY FORM

(rev. 10/09)

Name_____ Phone #_____ Date_____

Age_____Birth Date_____Marital Status: S M Sep W D Current Job_____

Primary Care Provider_____Office Location_____
When was the last visit with your Primary Care Provider?_____

List current medications / vitamins / herbs	List any known drugs you are allergic to including latex

Birth control method _____

No Yes
- ☐ ☐ Have you had any new medical problems or surgeries since your last visit? Please describe:_____
- ☐ ☐ Have any of your family members had any new medical problems or surgeries since your last visit? Please describe:_____

REVIEW OF SYSTEMS: Are you experiencing any problems the following conditions? Please indicate yes or no to all.

No	Yes		No	Yes		No	Yes	
☐	☐	Wt loss/gain > 10 lbs	☐	☐	Epilepsy/seizures	☐	☐	Breast discharge
☐	☐	Fatigue	☐	☐	Diabetes	☐	☐	Breast problems
☐	☐	Chest pain	☐	☐	Thyroid problems	☐	☐	Constipation/diarrhea
☐	☐	Heart palpitations	☐	☐	Dizziness	☐	☐	Abdominal pain
☐	☐	Edema/swelling	☐	☐	Numbness or tingling of extremities	☐	☐	Bloody stool
☐	☐	Frequent cough				☐	☐	Urinary urgency/frequency
☐	☐	Shortness of breath	☐	☐	Headaches	☐	☐	Loss of urine
☐	☐	Muscle weakness	☐	☐	Bruising	☐	☐	Urinary problems
☐	☐	Loss of height	☐	☐	Unusual bleeding	☐	☐	Sexual problems
☐	☐	Depression/anxiety	☐	☐	Swollen glands	☐	☐	Vaginal problems
☐	☐	Physical/mental abuse	☐	☐	Rashes	☐	☐	Abnormal/irregular periods
☐	☐	Hot flashes	☐	☐	Breast pain			

WELLNESS

No Yes
- ☐ ☐ Smoke How much per day_____How long_____
- ☐ ☐ Drink alcohol How much per day_____How long_____
- ☐ ☐ Use drugs How much per day_____How long_____
- ☐ ☐ Caffeine How much per day_____How long_____
- ☐ ☐ Get enough calcium (1200 mg daily)?
- ☐ ☐ Do monthly self breast exams?
- ☐ ☐ Always wear your seat belt?
- ☐ ☐ Exercise? Type & freq._____
- ☐ ☐ Are you current with dental care?
- ☐ ☐ Are you on any particular diet?
- ☐ ☐ Do you have a health care proxy?
- ☐ ☐ 3 Gardasil Vaccinations completed (if < age 27)

Date of your last:
- _____ Pap Smear
- _____ Mammogram
- _____ Bone Density test
- _____ Cholesterol test (if over age 35)
- _____ Tetanus immunization (every 10 yrs)
- _____ Pneumonia immunization (if over age 65)
- _____ Sigmoidoscopy/colonoscopy (if > age 50)
- _____ Stool test for blood (if over age 50)

DO YOU WANT INFORMATION REGARDING:

☐ Self breast exams	☐ Health care proxy	☐ Advance care directives
☐ Vitamins	☐ Colon cancer	☐ Urine Loss
☐ Osteoporosis	☐ Infertility	☐ Hormone replacement therapy
☐ Contraception	☐ Menopause	☐ Sexually transmitted diseases

DO YOU WANT:

☐ A chaperone With Exam ☐ HIV Testing ☐ Sexual Disease Testing

Do you have any problems or concerns that you would like to discuss with your physician today? _____

Patient's Signature_____Date_____

OFFICE USE ONLY:

I have reviewed the above and personally discussed with the patient _____ M.D. Date_____

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CONSENT TO RELEASE MEDICAL INFORMATION

I authorize Southeast OB/GYN to obtain/release information regarding:

PATIENT NAME: _____ DOB: _____
ADDRESS: _____

_____ _____
Patient Signature Today's Date

( ) All medical records: **DO** release **HIV/AIDS** and /or sexually transmitted disease-related and/or psychological treatment and/or drug/alcohol abuse treatment information, if applicable. I understand that this is a dual release inclusive of sensitive medical information, including HIV.

( ) All medical records **with exception** of: _____
_____

( ) Send/obtain **only the following** information: _____
_____

( ) I am **transferring care** to this physician/facility: _____
_____
Reason for transferring care is ( ) MOVING ( ) INSURANCE CHANGE ( ) OTHER, please specify: _____
_____
_____

I authorize Southeast OB/GYN to OBTAIN/RELEASE information from/to the following:

Physician Name: _____ Phone: _____
Address: _____
_____
Fax number to obtain/send records: _____

I understand that my consent to release or obtain information will expire one year from the date of signature. I also understand that I may withdraw this consent at any time in writing.

For permanent records transfer, there is a fee of $.75 per page for copying and administrative costs. The fee will not exceed $20.00.

This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or otherwise permitted by law. Any unauthorized disclosure is in violation of state law and may result in a fine, jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further discolsure.

About Our Fees

Dear Patient:

Our fees are based on the time our providers spend with you during your visit, the complexity of your medical condition, and any treatment they provide. But proper attention to your care also requires that they - or members of our staff – spend *additional* time beyond that which we spend with you in the office. Such time may be used to, but is not limited to:

- Create or maintain your permanent medical record.
- Review, interpret, and document lab test results and communicate those results – orally or in writing – to you.
- Review current X-Ray or scan results, compare them with reports of previous results if applicable, and when the studies are abnormal, consult with the radiologist.
- Prepare and mail consultation reports and letters to patients who need to come in for a follow-up visit to follow-up on a previous medical problem.
- Consult via phone about your case with referring or consulting physicians and other health care providers.
- Prepare referral letters to additional specialists or primary care providers, as needed.
- Prepare patient education materials.
- Conduct medical research relevant to your case.
- Communicate with pharmacies about your prescriptions.
- Complete insurance applications and claim forms.
- Conduct utilization review negotiations with hospitals and insurance companies.
- Review and manage hospital records.
- Draft letters of necessity to obtain medical services, instruments or prescriptions that you need.
- Arrange for hospital admission and surgery and follow-up consultations with nurses, attending physicians, and residents.
- Draft reports and forms, including home health care orders and other service orders.

All these activities add to our cost of doing business. We are committed to providing you the best possible care at the lowest cost. We hope this explanation of our fees has been helpful. With you, our patient, we look forward to a lasting and healthy relationship.

FINANCIAL POLICY:

Thank you for choosing us as your health care provider. This following is a statement of our Financial Policy.

* Full payment is due at the time of service. We accept:, Visa, MasterCard, checks, and cash.

*We participate in a variety of insurance companies. It is your responsibility to make sure we are a participating provider of your insurance carrier prior to your office visit.

* All co-payments and deductible amounts are due prior to treatment. In the event that you have, or change to an insurance plan in which we do not participate, full payment of services rendered will be due at that time.

* If it becomes necessary to bill you for amounts due at the time of service, a billing fee will be applied.

* Our practice is committed to providing the best treatment for our patients, and we charge usual and customary fees for our area. Thus, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

NOTE: If you come to your preventative health care service visit (an annual) with symptoms of an active medical problem that your provider needs to address, additional evaluation and management services may be performed on the same day or you may schedule an appointment to receive that service at a later date. The associated charges for this additional service may be handled differently by your health plan than your preventative service and you may be personally responsible for additional co-payments, deductibles or other out-of-pocket expenses as determined by your health plan.

PATIENT CONSENT, AGREEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:

I, the undersigned, consent to the use and disclosure of my protected health information for treatment, payment and operations and such other purposes that are permitted under the Federal Health Insurance Portability and Accountability Act (HIPAA) without a written authorization. I accept that I am financially responsible for all services rendered on my behalf by Southeast Obstetrics and Gynecology, PC (the practice). For those insurance plans for which the Practice accepts assignment. I accept personal responsibility for all co-payments, deductibles and non -covered services, as dictated by my insurance coverage. I authorize payment directly to The Practice for services which The Practice accepts assignment. I have read and agree to the Financial Policy. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct.

_____ _____

Signature of Patient Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE (HIPAA):

By signing below I acknowledge that I received a copy of Southeast OB/GYN's notice of Privacy Practices.

_____ _____

Signature of Patient or Parent/Legal Representative Date

If not the patient, please print your name and indicate your relationship to the patient:

_____ _____

Printed Name Relationship to Patient

PATIENT'S AUTHORIZATION TO RELEASE PROTECTED MEDICAL INFORMATION (THIS IS OPTIONAL): By signing below, I am authorizing said family member, friend, or other person to receive information regarding my health and protected health information. **To the patient:** Please note if no person is stated below, you will be the only one to make appointments, call for prescription refills and/or discuss health concerns. Please note that you at any time can take a person on/off your list.

Names of persons allowed to get the above mentioned information (please print):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE **DATE**

Screening Questionnaire for Vaccination

HPV 1 _____(now) Tetanus Flu
2 _____(2 months after 1st; not < 28 days)
3 _____(6 months after 1st; 6-12 months)

Patient Name: _____DOB:_____Date:_____

S:

The following questions will help us determine which vaccines you may be given today. If a question is not clear, please ask your healthcare provider to explain it.			
	Yes	**No**	**Don't Know**
1. Have you ever had a reaction to yeast?			
2. Do you have a sensitivity to eggs or egg products or other severe food allergies?			
3. Do you have a history of Gillian-Barre Syndrome?			
4. Are you sick today?			
5. Do you have a known sensitivity to Thimersol (a preservative in vaccines)?			
6. Have you ever had a serious reaction after receiving a vaccine?			
7. Do you have cancer, leukemia, AIDS, or any other immune system problem?			
8. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had any radiation (x-ray) treatments?			
9. During the past year, have you received a transfusion of blood or blood products, or been given a medication called immune (gamma) globulin?			
10. ** Are you pregnant or is there a chance you could become pregnant during the next 3 months?			
11. ** Have you received any vaccinations in the past 4 weeks?			
12. ** Are you currently breastfeeding?			

O: BP _____ WT _____

A: Eligible for HPV vaccine today ? Y_____ N_____

P: Administer vaccine.

Gardasil_____ Other_____	Lot #: Expiration Date: _____	Site:_____

I understand that if I am over the age of 26 that the HPV vaccine is not currently recommended by the FDA, because it has not been studied in this age group, and may not be covered by my insurance.

I also understand that it is my responsibility to ascertain if my insurance will cover the vaccine that I have requested. I am responsible for partial or full payment if not covered.

Patient Signature _____ Date _____

Reviewed by _____ Date _____

VACCINE INFORMATION STATEMENT

HPV Vaccine Gardasil® (Human Papillomavirus)

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 What is HPV?

Genital **human papillomavirus (HPV)** is the most common sexually transmitted virus in the United States. More than half of sexually active men and women are infected with HPV at some time in their lives.

About 20 million Americans are currently infected, and about 6 million more get infected each year. HPV is usually spread through sexual contact.

Most HPV infections don't cause any symptoms, and go away on their own. But HPV can cause **cervical cancer** in women. Cervical cancer is the 2nd leading cause of cancer deaths among women around the world. In the United States, about 12,000 women get cervical cancer every year and about 4,000 are expected to die from it.

HPV is also associated with several less common cancers, such as vaginal and vulvar cancers in women, and anal and oropharyngeal (back of the throat, including base of tongue and tonsils) cancers in both men and women. HPV can also cause genital warts and warts in the throat.

There is no cure for HPV infection, but some of the problems it causes can be treated.

2 HPV vaccine: Why get vaccinated?

The HPV vaccine you are getting is one of two vaccines that can be given to prevent HPV. It may be given to both males and females.

This vaccine can prevent most cases of cervical cancer in females, if it is given before exposure to the virus. In addition, it can prevent vaginal and vulvar cancer in females, and genital warts and anal cancer in both males and females.

Protection from HPV vaccine is expected to be long-lasting. But vaccination is not a substitute for cervical cancer screening. Women should still get regular Pap tests.

3 Who should get this HPV vaccine and when?

HPV vaccine is given as a 3-dose series

1st Dose	Now
2nd Dose	1 to 2 months after Dose 1
3rd Dose	6 months after Dose 1

Additional (booster) doses are not recommended.

Routine vaccination

- This HPV vaccine is recommended for girls and boys **11 or 12 years of age**. It *may* be given starting at age 9.

Why is HPV vaccine recommended at 11 or 12 years of age?

HPV infection is easily acquired, even with only one sex partner. That is why it is important to get HPV vaccine before any sexual contact takes place. Also, response to the vaccine is better at this age than at older ages.

Catch-up vaccination

This vaccine is recommended for the following people who have not completed the 3-dose series:

- Females 13 through 26 years of age.
- Males 13 through 21 years of age.

This vaccine *may* be given to men 22 through 26 years of age who have not completed the 3-dose series.

It is *recommended* for men through age 26 who have sex with men or whose immune system is weakened because of HIV infection, other illness, or medications.

HPV vaccine may be given at the same time as other vaccines.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

VACCINE INFORMATION STATEMENT

Tdap Vaccine (Tetanus, Diphtheria, and Pertussis)

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Tetanus, diphtheria and **pertussis** can be very serious diseases, even for adolescents and adults. Tdap vaccine can protect us from these diseases.

TETANUS (Lockjaw) causes painful muscle tightening and stiffness, usually all over the body.

- It can lead to tightening of muscles in the head and neck so you can't open your mouth, swallow, or sometimes even breathe. Tetanus kills about 1 out of 5 people who are infected.

DIPHTHERIA can cause a thick coating to form in the back of the throat.

- It can lead to breathing problems, paralysis, heart failure, and death.

PERTUSSIS (Whooping Cough) causes severe coughing spells, which can cause difficulty breathing, vomiting and disturbed sleep.

- It can also lead to weight loss, incontinence, and rib fractures. Up to 2 in 100 adolescents and 5 in 100 adults with pertussis are hospitalized or have complications, which could include pneumonia or death.

These diseases are caused by bacteria. Diphtheria and pertussis are spread from person to person through coughing or sneezing. Tetanus enters the body through cuts, scratches, or wounds.

Before vaccines, the United States saw as many as 200,000 cases a year of diphtheria and pertussis, and hundreds of cases of tetanus. Since vaccination began, tetanus and diphtheria have dropped by about 99% and pertussis by about 80%.

2 Tdap vaccine

Tdap vaccine can protect adolescents and adults from tetanus, diphtheria, and pertussis. One dose of Tdap is routinely given at age 11 or 12. People who did *not* get Tdap at that age should get it as soon as possible.

Tdap is especially important for health care professionals and anyone having close contact with a baby younger than 12 months.

Pregnant women should get a dose of Tdap during *every* pregnancy, to protect the newborn from pertussis. Infants are most at risk for severe, life-threatening complications from pertussis.

A similar vaccine, called Td, protects from tetanus and diphtheria, but not pertussis. A Td booster should be given every 10 years. Tdap may be given as one of these boosters if you have not already gotten a dose. Tdap may also be given after a severe cut or burn to prevent tetanus infection.

Your doctor can give you more information.

Tdap may safely be given at the same time as other vaccines.

3 Some people should not get this vaccine

- If you ever had a life-threatening allergic reaction after a dose of any tetanus, diphtheria, or pertussis containing vaccine, OR if you have a severe allergy to any part of this vaccine, you should not get Tdap. Tell your doctor if you have any severe allergies.
- If you had a coma, or long or multiple seizures within 7 days after a childhood dose of DTP or DTaP, you should not get Tdap, unless a cause other than the vaccine was found. You can still get Td.
- Talk to your doctor if you:
  - have epilepsy or another nervous system problem,
  - had severe pain or swelling after any vaccine containing diphtheria, tetanus or pertussis,
  - ever had Guillain-Barré Syndrome (GBS),
  - aren't feeling well on the day the shot is scheduled.

CDC U.S. Department of Health and Human Services Centers for Disease Control and Prevention