

**National Vaccine Information Center**

November 2008

[www.NVIC.org](http://www.NVIC.org)**Gardasil Network Development Project**  
**GARDASIL VACCINE QUESTIONNAIRE**

Answering this questionnaire is voluntary. Personal identifying information will not be shared with anyone outside of NVIC without permission. Published reports using information from questionnaires for the purpose of analyzing adverse health events following vaccination with Gardasil will not include any personal identifying information.

Please note, because Gardasil is usually given to persons under 18 years of age, it is assumed that the person who has experienced an adverse event following vaccination (referred to as the "patient") is not necessarily the person completing the questionnaire (referred to as the "reporter"). If the patient is a minor under the age of 18, the questionnaire should be completed with the assistance of the parent or legal guardian.

Because it is important to know whether other vaccines were given at the same time Gardasil was given, it will be helpful to have the patient's shot records available when completing the questionnaire.

Thank you for your help in gathering information about Gardasil vaccine.

**Section 1. Demographic Information** (Please answer each question)

1. Today's Date:

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
month/		day/	year						

2. Name of Reporter:

Last,

First

3. Email Address:

Primary

Secondary

4. Phone Number:

( <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> )	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	-	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Primary			

( <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> )	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	-	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Secondary			

5. Mailing Address:

Street

City

State

Zipcode

6. Name of Patient:

Last,

MI

First

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7. Reporter's Relationship to Patient: (Please check one)

Self  
 Mother  
 Father  
 Sibling  
 Grandparent  
 Family (other) (please specify) \_\_\_\_\_  
 Friend  
 Patient's Doctor

8. Gender/sex of Patient: (Please check one)

Female  
 Male



9. Patient's Age (Please enter birthdate and check box for current age range. If patient is deceased, please enter patient's age range at time of death.)

Birthdate:   /     AND Age range categories:

<input type="checkbox"/> under 5 years	<input type="checkbox"/> 17 – 18 years
<input type="checkbox"/> 5 – 8 years	<input type="checkbox"/> 19 – 20 years
<input type="checkbox"/> 9 – 10 years	<input type="checkbox"/> 21 – 23 years
<input type="checkbox"/> 11 – 12 years	<input type="checkbox"/> 24- – 26 years
<input type="checkbox"/> 13 – 14 years	<input type="checkbox"/> over 26 years
<input type="checkbox"/> 15 – 16 years	

**Section 2. Patient and Family Health History Prior to First Gardasil Shot (Please answer each question.)**

10. BEFORE Gardasil shots were given, did the patient have a history of any of the following problems? (Please check "YES", "NO" or "UNSURE" for each problem.)

YES	NO	UNSURE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever of 100F or greater <u>at the time of vaccination</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat or other illness signs <u>at the time of vaccination</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gluten allergy (allergic to wheat, oats, barley or rye)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Casein allergy (allergic to milk, dairy, butter or cheese)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peanut or other food allergy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other antibiotic allergy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pollen, mold or other environmental allergy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin disorders such as eczema, rashes or acne
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or convulsions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis (including Guillain Barre Syndrome)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis or lupus
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney, pancreas or liver disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaccine reactions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brain inflammation (encephalitis or encephalopathy)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skipped heart beats or heart disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or sudden collapse
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual or hormone problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital warts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HPV infection or cervical dysplasia or cervical cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel or gastrointestinal problems (chronic constipation/diarrhea)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thrombocytopenia or other blood disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify) _____

11. BEFORE Gardasil shots were given, (Check "YES", "NO" or "UNSURE" for each question below.)

a. Was the patient in good health most of the time?

YES  
 NO  
 UNSURE

b. Was the patient an athlete?

YES  
 NO  
 UNSURE

c. Did the Patient have a 3.0 (B) or greater grade point average or above-average intelligence (115 I.Q. or greater)?

YES  
 NO  
 UNSURE



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12. BEFORE Gardasil shots were given, did a member of the patient's family have a history of any of the following problems? (Please check "YES", "NO" or "UNSURE" for each problem if it occurred in the patient's mother, father, siblings or grandparents.)

YES	NO	UNSURE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gluten allergy (allergic to wheat, oats, barley or rye)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Casein allergy (allergic to milk, dairy, butter or cheese)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peanut or other food allergy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other antibiotic allergy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pollen, mold or other environmental allergy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin disorders such as eczema, rashes or acne
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or convulsions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis (including Guillain Barre Syndrome)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis or lupus
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney, pancreas or liver disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaccine reactions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brain inflammation (encephalitis or encephalopathy)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skipped heart beats or heart disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or sudden collapse
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual or hormone problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital warts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HPV infection or cervical dysplasia or cervical cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel or gastrointestinal problems (chronic constipation/diarrhea)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thrombocytopenia or other blood disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify) _____

**Section 3. Vaccination and Reaction History**

Gardasil is recommended to be given in a series of three shots. The next set of questions will be repeated for each of the three Gardasil shots and will ask about other vaccines that may have been given along with the Gardasil and any reactions that may have occurred following each of the Gardasil shots. (Please answer each question.)

13. Regarding the **FIRST** Gardasil shot...

Date the **FIRST** Gardasil shot was given:

/   /

month/ day/ year

Vaccine Lot number if known: \_\_\_\_\_  
(should be recorded on shot record)

14. What other vaccines, if any, did the patient receive at the SAME time the **FIRST** Gardasil shot was given? (Please consult patient's vaccination record and check "YES", "NO" or "UNSURE" for each vaccine.)

YES	NO	UNSURE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meningococcal (MPSV4, pediatric)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meningococcal (MCV4, adolescents and adults)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Influenza (TIV, inactivated)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Influenza (LAIV, nasal, live virus)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (HBV)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (HAV)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox (VAR, any varicella-containing vaccine)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MMR (measles-mumps-rubella or any combination)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tdap or DTaP (diphtheria-tetanus-acellular pertussis)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DTP (diphtheria-tetanus-whole-cell pertussis)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DT or Td (diphtheria-tetanus)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BCG (tuberculosis)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio (IPV, inactivated)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio (OPV, oral, live virus)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcal (PCV7 or PCV, infants)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcal (PPV23 or PPV, children, adolescents and adults)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hib (haemophilus influenzae type B)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rotavirus (ROTA or PRV)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles Zoster (ZOS)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anthrax (AVA)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify) _____

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15. What other medications and other over-the-counter products, if any, was the patient taking at the time the **FIRST** Gardasil shot was given? (Please check "YES", "NO" or "UNSURE" for each product.)

YES	NO	UNSURE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Birth control pills
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anti-depressants
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acne medication (pills)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other prescription drugs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vitamins or health supplements
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify) _____

16. Was the patient pre-menstrual or menstruating at the time the **FIRST** Gardasil shot was given? (Please check "YES", "NO" or "UNSURE".)

YES	NO	UNSURE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pre-menstrual
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstruating



17. What symptoms, if any, did the patient report after **FIRST** Gardasil shot was given (but before the **SECOND** shot, if given)? (Please check "YES", "NO" or "UNSURE" for each symptom.)

YES	NO	UNSURE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immediate collapse or unconsciousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Collapse within 24 hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Collapse after 24 hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or convulsions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever 100F or greater
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extreme fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skipped heart beats/ heart disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis (including Guillian Barre Syndrome)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision or vision loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rashes, blisters, or skin disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital warts or warts on other body parts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concentration problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Personality change
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression or other alteration in mood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual or hormonal problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HPV infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cervical dysplasia or cancer lesion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia or other viral or bacterial infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thrombocytopenia or other blood disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	New food, drug or environmental allergies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of weight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gain of weight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brain inflammation (encephalopathy and encephalitis)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea and vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in bowel habits (diarrhea and constipation)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Death
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify) _____

18. How soon after the **FIRST** Gardasil shot was given did the **FIRST SYMPTOM**, if any, appear? (Please check the best choice.)

<input type="checkbox"/> Does not apply, no symptoms were present	<b>OR</b>	(Please select the best choice)
		<input type="checkbox"/> Immediately (within 20 minutes)
		<input type="checkbox"/> Within 24 hours
		<input type="checkbox"/> Within 72 hours
		<input type="checkbox"/> Within 7 days
		<input type="checkbox"/> Within 14 days
		<input type="checkbox"/> Within 30 days
		<input type="checkbox"/> After 30 days

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19. Regarding the **SECOND** Gardasil shot (Please enter date shot given OR indicate that second Gardasil shot was NOT given).

a. Date the **SECOND** Gardasil shot was given: / /   
 month/ day/ year      Vaccine Lot number if known: \_\_\_\_\_  
 (should be recorded on shot record)

**OR**

b.  Patient did NOT receive **SECOND** Gardasil shot (please go to Question 35)

20. What other vaccines, if any, did the patient receive at the SAME time the **SECOND** Gardasil shot was given? (Please consult patient's vaccination record and check "YES", "NO" or "UNSURE" for each vaccine.)

YES	NO	UNSURE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meningococcal (MPSV4, pediatric)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meningococcal (MCV4, adolescents and adults)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Influenza (TIV, inactivated)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Influenza (LAIV, nasal, live virus)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (HBV)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (HAV)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox (VAR, any varicella-containing vaccine)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MMR (measles-mumps-rubella or any combination)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tdap or DTaP (diphtheria-tetanus-acellular pertussis)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DTP (diphtheria-tetanus-whole-cell pertussis)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DT or Td (diphtheria-tetanus)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BCG (tuberculosis)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio (IPV, inactivated)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio (OPV, oral, live virus)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcal (PCV7 or PCV, infants)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcal (PPV23 or PPV, children, adolescents and adults)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hib (haemophilus influenzae type B)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rotavirus (ROTA or PRV)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles Zoster (ZOS)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anthrax (AVA)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify) _____

21. What other medications and other over-the-counter products, if any, was the patient taking at the time the **SECOND** Gardasil shot was given? (Please check "YES", "NO" or "UNSURE" for each product.)

YES	NO	UNSURE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Birth control pills
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anti-depressants
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acne medication (pills)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other prescription drugs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vitamins or health supplements
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify) _____



22. Was the patient pre-menstrual or menstruating at the time the **SECOND** Gardasil shot was given? (Please check "YES", "NO" or "UNSURE".)

YES	NO	UNSURE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pre-menstrual
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstruating

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23. What symptoms, if any, did the patient report after **SECOND** Gardasil shot was given (but before the **THIRD** shot, if given)? (Please check "YES", "NO" or "UNSURE" for each symptom.)

YES	NO	UNSURE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immediate collapse or unconsciousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Collapse within 24 hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Collapse after 24 hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or convulsions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever 100F or greater
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extreme fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skipped heart beats/ heart disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis (including Guillian Barre Syndrome)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision or vision loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rashes, blisters, or skin disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital warts or warts on other body parts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concentration problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Personality change
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression or other alteration in mood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual or hormonal problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HPV infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cervical dysplasia or cancer lesion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia or other viral or bacterial infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thrombocytopenia or other blood disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	New food, drug or environmental allergies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of weight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gain of weight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brain inflammation (encephalopathy and encephalitis)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea and vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in bowel habits (diarrhea and constipation)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Death
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify) _____

24. Were any of these symptoms present after the **FIRST** Gardasil shot? (Please check "YES", "NO" or "UNSURE".)

- YES
- NO (go to Question 26)
- UNSURE (go to Question 26)

25. Did the symptoms that were present after the **FIRST** Gardasil shot get worse after the **SECOND** shot? (Please check "YES", "NO" or "UNSURE".)

- YES
- NO
- UNSURE

26. How soon after the **SECOND** Gardasil shot was given did the **FIRST SYMPTOM** (or worsening of existing symptoms), if any, appear? (Please check the best choice.)

Does not apply, no symptoms were present

OR

- (Please select the best choice)
- Immediately (within 20 minutes)
  - Within 24 hours
  - Within 72 hours
  - Within 7 days
  - Within 14 days
  - Within 30 days
  - After 30 days

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27. Regarding the **THIRD** Gardasil shot (Please enter date shot given OR indicate that third Gardasil shot was NOT given).

a. Date the **THIRD** Gardasil shot was given: //  
 month/ day/ year Vaccine Lot number if known: \_\_\_\_\_  
 (should be recorded on shot record)

**OR**

b.  Patient did NOT receive **THIRD** Gardasil shot (please go to Question 35)

28. What other vaccines, if any, did the patient receive at the **SAME** time the **THIRD** Gardasil shot was given? (Please consult patient's vaccination record and check "YES", "NO" or "UNSURE" for each vaccine.)

YES	NO	UNSURE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meningococcal (MPSV4, pediatric)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meningococcal (MCV4, adolescents and adults)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Influenza (TIV, inactivated)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Influenza (LAIV, nasal, live virus)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (HBV)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (HAV)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox (VAR, any varicella-containing vaccine)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MMR (measles-mumps-rubella or any combination)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tdap or DTaP (diphtheria-tetanus-acellular pertussis)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DTP (diphtheria-tetanus-whole-cell pertussis)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DT or Td (diphtheria-tetanus)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BCG (tuberculosis)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio (IPV, inactivated)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio (OPV, oral, live virus)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcal (PCV7 or PCV, infants)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcal (PPV23 or PPV, children, adolescents and adults)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hib (haemophilus influenzae type B)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rotavirus (ROTA or PRV)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles Zoster (ZOS)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anthrax (AVA)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify) _____

29. What other medications and other over-the-counter products, if any, was the patient taking at the time the **THIRD** Gardasil shot was given? (Please check "YES", "NO" or "UNSURE" for each product.)

YES	NO	UNSURE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Birth control pills
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anti-depressants
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acne medication (pills)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other prescription drugs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vitamins or health supplements
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify) _____

30. Was the patient pre-menstrual or menstruating at the time the **THIRD** Gardasil shot was given? (Please check "YES", "NO" or "UNSURE".)

YES	NO	UNSURE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pre-menstrual
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstruating

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31. What symptoms, if any, did the patient report after **THIRD** Gardasil shot was given? (Please check "YES", "NO" or "UNSURE" for each symptom.)

YES	NO	UNSURE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immediate collapse or unconsciousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Collapse within 24 hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Collapse after 24 hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or convulsions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever 100F or greater
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extreme fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skipped heart beats/ heart disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis (including Guillian Barre Syndrome)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision or vision loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rashes, blisters, or skin disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital warts or warts on other body parts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concentration problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Personality change
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression or other alteration in mood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual or hormonal problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HPV infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cervical dysplasia or cancer lesion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia or other viral or bacterial infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thrombocytopenia or other blood disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	New food, drug or environmental allergies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of weight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gain of weight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brain inflammation (encephalopathy and encephalitis)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea and vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in bowel habits (diarrhea and constipation)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Death
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify) _____

32. Were any of these symptoms present after the **SECOND** Gardasil shot? (Please check "YES", "NO" or "UNSURE".)

- YES
- NO (go to Question 34)
- UNSURE (go to Question 34)

33. Did the symptoms that were present after the **SECOND** Gardasil shot get worse after the **THIRD** shot? (Please check "YES", "NO" or "UNSURE".)

- YES
- NO
- UNSURE

34. How soon after the **THIRD** Gardasil shot was given did the **FIRST SYMPTOM** (or worsening of existing symptoms), if any, appear? (Please check the best choice.)

Does not apply, no symptoms were present

OR

- (Please select the best choice)
- Immediately (within 20 minutes)
  - Within 24 hours
  - Within 72 hours
  - Within 7 days
  - Within 14 days
  - Within 30 days
  - After 30 days

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**Section 4. Current Health Condition**

35. What symptoms, if any, is the Patient continuing to experience today: (Please check "YES", "NO" or "UNSURE" for each symptom.)

YES	NO	UNSURE	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Collapse or fainting spells
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or convulsions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extreme fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skipped heart beats/ heart disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis (including Guillian Barre Syndrome)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision or vision loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rashes, blisters, or skin disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital warts or warts on other body parts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concentration problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Personality change
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression or other alteration in mood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual or hormonal problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HPV infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cervical dysplasia or cancer lesion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia or other viral or bacterial infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thrombocytopenia or other blood disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	New food, drug or environmental allergies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of weight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gain of weight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brain inflammation (encephalopathy and encephalitis)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea and vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in bowel habits (diarrhea and constipation)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify) _____

<p>36. Is the Patient deceased? (Please check "YES" or "NO".)</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO (Go to Question 42)</p>	➔	<p>37. Please enter date of death: <input type="text"/>/ <input type="text"/>/ <input type="text"/></p> <p align="center">month/ day/ year</p>
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38. Please note whether Patient died after **FIRST**, **SECOND** or **THIRD** Gardasil shot? (Please check one answer.)

Patient died after **FIRST** but before the **SECOND** Gardasil shot.

Patient died after **SECOND** but before the **THIRD** Gardasil shot.

Patient died after **THIRD** Gardasil shot.

<p>39. How long between the last Gardasil shot given and the time of death? (Please check the best answer.)</p> <p><input type="checkbox"/> Within 4 hours.</p> <p><input type="checkbox"/> Within 24 hours.</p> <p><input type="checkbox"/> Within 48 hours.</p> <p><input type="checkbox"/> Within 72 hours.</p> <p><input type="checkbox"/> Within 7 days.</p> <p><input type="checkbox"/> Within 14 days.</p> <p><input type="checkbox"/> Within 30 days.</p> <p><input type="checkbox"/> After 30 days.</p>	<p>40. Was an autopsy performed? (Please check "YES" or "NO".)</p> <p><input type="checkbox"/> YES                      <input type="checkbox"/> NO (Please go to Question 42)</p> <p>41. What cause of death was noted in the autopsy report? (Please check the best answers.)</p> <p><input type="checkbox"/> No "cause of death" noted.</p> <p><input type="checkbox"/> Viral or bacterial infection.</p> <p><input type="checkbox"/> Heart failure.</p> <p><input type="checkbox"/> Embolism or stroke.</p> <p><input type="checkbox"/> Seizure.</p> <p><input type="checkbox"/> Other (Please specify) _____</p>
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## Section 5. Reaction Report and Follow-up Care

42. Was the health care problem or death following Gardasil reported to the federal Vaccine Adverse Event Reporting (VAERS) system? (Please check "YES", "NO" or "UNSURE".)

- YES  
 NO (Go to Question 44)  
 UNSURE (Go to Question 44)

43. Did a government health official or vaccine manufacturer representative contact you to follow up on the Gardasil adverse event report? (Please check "YES", "NO" or "UNSURE".)

- YES  
 NO  
 UNSURE

44. Was the Patient or Guardian given written Gardasil vaccine benefit/risk information **BEFORE** the first Gardasil shot was given? (Please check "YES", "NO" or "UNSURE".)

- YES  
 NO  
 UNSURE

45. Would you like to be contacted by email?

- YES  
 NO  
 UNSURE

46. Would you like to be contacted by phone?

- YES  
 NO  
 UNSURE

47. Would you like to be in contact with others who have experienced health problems after Gardasil vaccination?

- YES  
 NO  
 UNSURE

48. Would you consider speaking publicly about your experience with Gardasil vaccination?

- YES  
 NO  
 UNSURE

*Thank you for taking the time to complete this questionnaire. Please fax it back to NVIC at 703-938-5768 and an NVIC representative will contact you for further information as soon as possible. If you prefer, you can also mail it back to NVIC, 407-H Church Street, Vienna, VA 22180, Attention: Gardasil Development Network.*