INFLUENZA VACCINE PATIENT QUESTIONNAIRE

Print Name:_____ Phone #: _____

D.O.B:_____ Primary Care Physician:_____

CIRCLE ONE:

1. Were you given the Vaccine Information Statement? Yes No

2. Allergic to eggs/poultry? Yes No

3. Allergic to the presentative Thimerosal? Yes No

4. Allergic to Latex? Yes No

5. Any previous reaction/problem with the flu vaccine? Yes No

6. Ever paralyzed by Guillian-Barre Syndrome? Yes No

7. Currently experiencing any moderate or severe illness? Yes No

FEMALES:

Are you pregnant and /or nursing? Yes No

For "YES" response(s) EXCLUDING #1, we WILL NOT vaccinate you at this time. You must seek further advice from your Primary Care Physician.

By signing I acknowledge the following:

I have read or have had explained to me the information in the "Vaccine Information Statement" regarding the risk and benefits associated with the influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine recommended.

Signature:_____ Date:_____

For Office Use:

Vaccine:_____ Manufacture:_____ LOT#_____ EXP:_____

Dosage: 0.5ml Site: Left/Right Deltoid IM Signature of Technician:_____