

INFLUENZA VACCINE PATIENT QUESTIONNAIRE

Print Name:	Phone #: _		
D.O.B: Primary 0	Care Physician:		
		CIRCLE	ONE:
1. Were you given the Vaccine Information Stateme	ent?	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 vacc	ine?	Yes	No
6. Ever paralyzed by Guillian-Barre Syndrome?		Yes	No
7. Currently experiencing any moderate or severe i	lness?	Yes	No
FEMALES:			
Are you pregnant and /or nursing?		Yes	No
For "YES" response(s) EXCLUDING #1, we WILL NO advice from your Primary Care Physician.	OT vaccinate you at t	this tim	e. You must seek furthe
By signing I acknowledge the following:			
I have read or have had explained to me the in regarding the risk and benefits associated with questions that were answered to my satisfaction. vaccine recommended.	the influenza vaccir	ie. I ha	ve had a chance to as
Signature:	Date:		
For Office Use:			
Vaccine: Manufacture:	LOT#	EX	KP:
Dosage: 0.5ml Site: Left/Right Deltoid IM Si	gnature of Technicia	า:	