

# INFLUENZA VACCINE PATIENT QUESTIONNAIRE

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

1. Are you currently ill and/or have a fever today? Yes No
2. Have you ever had a reaction to the flu vaccine? Yes No
3. Have you ever had Guillian-Barre Syndrome? Yes No  
**Guillain-Barre Syndrome (GBS) is a severe paralyzing illness**
4. Allergy to latex? Yes No
5. Do you have an allergy to eggs or any component of the vaccine? Yes No

---

**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 vaccination. 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.

\_\_\_\_\_ Date: \_\_\_\_\_  
Patient Signature

\_\_\_\_\_ Date: \_\_\_\_\_  
If patient under 18 y/o parent/guardian signature

---

**For Office Use Only**

**Vaccine:** Fluzone / Fluarix/Fluvirin

**Manufacturer:** Sanofi Pastuer / GSK /Novartis

**Lot #:** \_\_\_\_\_

**VIS Date:** 07/16/07

**Dose:** 0.25ml or 0.5ml IM

**Site:** Left or Right  
Thigh or Deltoid

\_\_\_\_\_ Date: \_\_\_\_\_  
Administering Clinician's Signature