

## INFLUENZA VACCINE PATIENT QUESTIONNAIRE

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

Primary Care Provider: \_\_\_\_\_

- |                                                           |     |    |
|-----------------------------------------------------------|-----|----|
| 1. Vaccine Information Statement given:                   | Yes | No |
| 2. Allergy to any of the following:                       |     |    |
| • Eggs/Poultry                                            | Yes | No |
| • Pork                                                    | Yes | No |
| • Latex                                                   | Yes | No |
| • Preservative thimersol                                  | Yes | No |
| 3. Any previous reaction /problem with flu vaccines:      | Yes | No |
| 4. Ever paralyzed by Guillian-Barre Syndrome:             | Yes | No |
| 5. Currently experiencing any moderate to severe illness: | Yes | No |
| 6. Pregnant:                                              | Yes | No |
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### By signing I acknowledge the following:

I have read or have had explained to me the information in the "Vaccine Information Statement" regarding the risks 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: \_\_\_\_\_

Guardian Signature (if applicable)

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### *For Office Use Only*

**Vaccine:** Fluzone      **Manufacturer:** Sanofi Pasteur      **Lot#:** \_\_\_\_\_

**Dose:** 0.25ml or 0.5ml IM      **Site:** Left or Right Thigh or Deltoid

\_\_\_\_\_ Date: \_\_\_\_\_

Administering Clinician's Signature