

ADULT 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 |
| • Neosporin or Neomycin | 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 |

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)

For Office Use Only

Vaccine: _____ **Manufacturer:** _____ **Lot#:** _____

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

_____ Date: _____

Administering Clinician's Signature