

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 |

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