Shah and Associates Family Practice
Influenza Questionnaire

Date: _____

Patient Name: _____ **DOB:** _____ **Age:**_____

Insurance Info: ☐ **Insured** ☐ **Uninsured/Private Pay** ☐ **Medicaid** ☐ **Medicare**
Name and relationship of person completing form: _____

There are specific requirements for each Influenza vaccine available:
1. Inactivated Influenza (IIV)-commonly referred to as the Flu Shot
2. Intradermal inactivated influenza-newest route of administration available
3. Live-intranasal influenza or Flu Mist

Therefore, before you receive *any* Flu vaccine, you must answer the questions below. Your health care provider will then review your answers to determine if you qualify for the vaccine, and if so, which vaccine is best for you.

Questions 1-4 are applicable for all flu vaccines **(fluzone, High dose fluzone, intradermal fluzone, and flu mist)**	Yes	No
1.Have you ever had a severe (life threatening) reaction to a previous dose of influenza vaccine?	☐	☐
2. Are you allergic to eggs?	☐	☐
3 Have you ever had Guillain-Barre syndrome or an active neurological disease?	☐	☐
4. Do you have a fever or illness today?	☐	☐
Questions 5 and 6 are applicable for **Flu Mist** ***only:***		
5. Are you pregnant? Or breast feeding?	☐	☐
6. Do you have any acute/chronic medical conditions such as:	☐	☐
Heart disease-----Diabetes----Kidney disease	☐	☐
Asthma or Reactive airway Disease (wheeze)-(been treated for disease in past 12 months?)	☐	☐
Weakened immune system----Cancer	☐	☐
Sickle Cell --- Thalassemia---- Anemia--- or other blood disorders?	☐	☐
7. Have you received any other vaccines in the past 4 weeks? (MMR, Varicella, PPD skin test, Zostavax)	☐	☐

I have truthfully answered all of the above questions. I have received a copy of the vaccine information sheet. I have had a chance to ask any questions I had related to the vaccine. I fully understand the benefit and risks of the influenza vaccination. My signature below indicates my permission to receive the influenza vaccine most appropriate for me.

Signature of Patient/Responsible Person authorizing vaccine administration:_____

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The Vaccine most appropriate for this patient, based on the above information provided, is:
_____1. Inactivated influenza (Shot) - *age 6mo-35mo (0.25ml)* ***or*** *36mo or older (0.5ml)*
_____2. Inactivated influenza- high dose (Shot) - *ages 65 and older*
_____3. Inactivated influenza (intradermal) - *non pregnant and ages 18 years-64 years*
_____4. Activated influenza (FluMist)-*non pregnant and healthy 2-49 year olds*

Lot#: _____Exp Date: _____ Route: **IM ID IN** Body site: **LA RA LT RT Nares** Nurse initials:_____