AstranaCare

VACCINE QUESTIONNAIRE

Name: _____ ☐ Male ☐ Female Date: _____

Phone: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Check Administered Vaccines
☐ Influenza (Flu) ☐ TDAP ☐ Shingrix Shingles Vaccine ☐ MCV (Meningococcal Vaccine)

Screening Questionnaire	
Are you currently ill or do you have a fever?	☐ Yes ☐ No ☐ Unknown
Have you received the flu vaccine before?	☐ Yes ☐ No ☐ Unknown
Have you had a reaction to the flu vaccine before?	☐ Yes ☐ No ☐ Unknown
Have you been sick in the last 2 weeks?	☐ Yes ☐ No ☐ Unknown
Are you allergic to egg or dairy products?	☐ Yes ☐ No ☐ Unknown
Are you allergic to latex, thimerosal, gelatin or a vaccine component?	☐ Yes ☐ No ☐ Unknown
Are you pregnant?	☐ Yes ☐ No ☐ Unknown
Are you a Health Care worker?	☐ Yes ☐ No ☐ Unknown
Have you ever had Guillain-Barre syndrome/seizure or a brain or other nervous system problem?	☐ Yes ☐ No ☐ Unknown
Do you have a blood-clot disorder?	☐ Yes ☐ No ☐ Unknown
Are you taking blood-thinning medication?	☐ Yes ☐ No ☐ Unknown

I, the undersigned, have read or had explained to me the vaccine information sheet (VIS). I understand the risks and benefits associated with the influenza vaccine and have had any questions satisfactorily answered. I voluntarily request that the vaccine be given to me or for the aforementioned person for whom I am authorized to make this request.

Patient Signature: _____ **Date:** _____