



Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

### Screening Questionnaire for Influenza Vaccination

**Please circle one answer to the following questions.**

Did the person to be vaccinated have seasonal influenza vaccine last flu season? (2021)      Yes      No      Don't Know

Has the person to be vaccinated:

- had fever in the last 24-48 hours?      Yes      No
- been tested or suspected of having COVID-19 in the last 14 days?      Yes      No
- been exposed to anyone who has been infected with or suspected to have COVID-19 in the last 14 days?      Yes      No
- Have cough, nasal congestion, runny nose, sore throat, loss of taste or smell, vomiting or diarrhea?      Yes      No

Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?      Yes      No      Don't Know

Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past (including Guillain Barre)?      Yes      No      Don't Know

Is the person to be vaccinated over 2 years old?      Yes      No

Is the person to be vaccinated over 50 years old?      Yes      No

Does the person to be vaccinated have any history of wheezing/asthma?      Yes      No  
If yes, approximately how long ago was the last episode of wheezing? \_\_\_\_\_

Is the person to be vaccinated currently taking aspirin daily?      Yes      No      Don't Know

Has the person to be vaccinated taken Tamiflu in the past 48 hrs., Xofluza in the last 3 weeks or any antiviral medication?      Yes      No      Don't Know

Has the person to be vaccinated received any live vaccines in the last 4 weeks? (MMR/Chickenpox)      Yes      No      Don't Know

Does the person to be vaccinated have a chronic disease or cochlear implants?      Yes      No

Is the person to be vaccinated in contact with someone whose immune system is suppressed? (HIV, cancer therapy)      Yes      No

Would you like FluMist if available and appropriate?      Yes      No

Is the person to be vaccinated pregnant?      Yes      No      Don't Know

#### Influenza Vaccination Policy

**Our office will file with your insurance for the administration of the influenza vaccination. If your insurance deems this as a non-covered expense, then you will be billed \$35 for standard Influenza vaccination and \$45 for nasal Flu Mist vaccination.**

Patient: \_\_\_\_\_  
(Please Print Name)

Parent Signature: \_\_\_\_\_

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

<b><u>FOR OFFICE USE ONLY</u></b>	
I have reviewed the above questionnaire:	
<b><u>Mist:</u></b>	
<input type="checkbox"/>	2 years – 49 years: PFQ FLUMIST 90672
<b><u>Injection</u></b>	
<input type="checkbox"/>	6 months - Adult: PFQ FLULAVAL 90686
<input type="checkbox"/>	6 months - Adult: PFQ FLUARIX 90686,3+
Needs another flu vaccine in _____ weeks	
Physician Signature: _____	