1230 Highway 70 E Suite1
New Bern, NC 28560

Patient Name: _____

DOB: _____

FLU Vaccine Questionnaire

Please answer the following questions to the best of your ability.	Yes	No	Don't Know
Are you sick today? (For example: cold, fever, or acute illness)			
Do you have allergies or reactions to medications, foods or any vaccine? (For example: Eggs, gelatin, neomycin, latex)			
Do you take anticoagulation medications? (For example: Coumadin, Warfarin, or other blood thinners)			
Do you have a long- term health problem with heart disease, lung disease, asthma, kidney disease, diabetes, anemia, or other blood disorders?			
Do you have cancer, leukemia, AIDS, or any other immune system problem?			
Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?			
Have you had a seizure, brain, or other nervous system problem?			
During the past year, have you received a transfusion of blood or blood products, or been given immune globulin or an antiviral drug?			
For Women: Are you pregnant or nursing? Could you become pregnant in the next month?			
Have you received any vaccinations in the past 4 weeks?			

NURSING USE ONLY: Date and Time:_____

Vital Signs: BP:_____/_____HR:_____RR:_____Temp:_____SP02:_____

Flu Vaccine:_____ Dose:_____

Lot#_____EXP:_____

Site:_____Staff Signature:_____

Patient Signature:_____Date:_____

☐ Patient Refused - Reason For Refusal:_____