

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

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

### **Screening Questionnaire for Influenza Immunizations**

This form helps us to decide which vaccines should be given in the pharmacy today. Please answer the following questions. Please see the pharmacist when completed.

1. Did you have a flu vaccine last year? Yes or No
2. Are you sick today?  
(If you are currently sick enough to go to the doctor or emergency room, you should postpone receiving a flu vaccine.) Yes or No
3. Do you have allergies to medications? Yes or No
4. Do you have allergies to eggs, any vaccine component? Yes or No
5. Have you ever had a serious reaction after receiving a vaccine? Yes or No
6. Do you, any person who lives with you, or any person you take care of, have cancer, leukemia, AIDS, or any other immune system problem?  
(Answering "Yes" is an extra reason to receive a flu vaccine.) Yes or No
7. Do you, any person who lives with you or any person you take care of, take cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatments?  
(Answering "Yes" is an extra reason to receive a flu vaccine.) Yes or No
8. During the past year, have you received a transfusion of blood or plasma, or been given a medicine called immune globulin? Yes or No
9. For women: Is it possible that you are pregnant or may become pregnant in the next three months?  
(Note: Influenza vaccines are recommended in pregnancy) Yes or No
10. Have you completed your immunization review at Discount Drug Mart within the last year? (If No, we can start the quick and easy process today.) Yes or No