Influenza Vaccination 2021 Questionnaire

**PLEASE BRING TO YOUR APPOINTMENT**

PERSONAL DETAILS

NAME: DOB:

ADDRESS:

Please answer the following questions:

If any of the responses to questions **3 – 7 below are “Yes” PLEASE CONTACT THE PRACTICE BEFORE YOUR APPOINTMENT**

|  |  |  |
| --- | --- | --- |
| QUESTION | YES (PLEASE TICK) |  NO (PLEASE TICK) |
| 1. Have you received the Seasonal Flu vaccine before? |  |  |
| 2. Do you have a bleeding disorder, or are you currently taking or have you recently stopped taking warfarin? |  |  |
| 3. Have you ever had a severe, life threatening allergic reaction to a Seasonal Flu vaccine in the past? |  |  |
| 4. Do you have a known history of a severe, life threatening allergic reaction to eggs and/or egg products? |  |  |
| 5. Do you have a known history of a severe, life threatening allergic reaction to latex? |  |  |
| 6. Do you have a known history of a severe, life threatening allergic reaction to gentamycin or neomycin? |  |  |
| 7. Do you have a known history of a severe, life threatening allergic reaction to formaldehyde? |  |  |

I have completed the information on this questionnaire to the best of my knowledge and am happy to receive the seasonal influenza vaccination today.

Signature:

Date: