WEST HARTFORD PEDIATRICS, LLC
785 Farmington Avenue
West Hartford, Connecticut 06119

Phone: 860. 523-4100 Fax: 860. 523-1462

PATIENT INFLUENZA VACCINE QUESTIONNAIRE

Patient Name:______________________________ Date of birth:____/____/____ age:___

Allergies:_____________________________ Current Medications:___________________

1. Has the patient ever had:

    a. A serious allergic reaction to egg or egg product (hives, swelling of lips or tongue, difficulty breathing, shock)?
    b. Giullain-Barré Syndrome — a serious neurological condition. **YES** **NO**

2. Has the patient had a fever in the past 24 hours? **YES** **NO**

3. Has the patient received the flu vaccine in the past? **YES** **NO**

4. Has the Vaccine Information Statement been provided for your review: **YES** **NO**
   (THE VACCINE INFORMATION STATEMENT IS LOCATED IN AN ORANGE BINDER IN EXAM ROOMS AND OUTSIDE OUR OFFICE DURING FLU CLINICS)

PATIENT if 18 years or older or Parent/Guardian signature:_____________________
Date:___________

Notes: ____
____

WAIVER: ONLY IF DECLINING THE INFLUENZA VACCINE, please date and initial:

Date:___/___/____ Initial:_____ The staff/medical provider has informed me of the risks associated with the influenza viral infection. I understand the risk of not vaccinating and choose to decline at this time.