

Health Screening Questionnaire for H1N1 (Swine Flu) Vaccine

Patient Name: _____ **Date of Birth:** _____

The following questions will help determine which vaccines may be given to the patient today. If you answer "yes" to any question, the patient may still get the vaccine, but additional questions must be asked first. Ask your health care provider to explain any unclear questions. Please answer the following questions about the patient (the person to be vaccinated).

Health Screening Questions	Mark Yes or No
1. I currently have a fever or respiratory illness or other type of infection.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I have sensitivities or allergies to foods (gelatin, eggs/egg protein) medications (gentamycin, Neosporin®, polymyxin B, vaccine components or have had a serious reaction to influenza vaccine in the past	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I have one of the following conditions or chronic illnesses: <ul style="list-style-type: none"> ▪ Diabetes, heart problems, kidney problems, ▪ Lung problems, including asthma ▪ History of recurrent or active wheezing, under the age of 5 years ▪ Conditions that make it difficult to keep the airway clear (spinal cord injuries, paralysis, seizure disorders, neuromuscular disorders, cognitive disorders) ▪ History of Guillian-Barré Syndrome; conditions that affect the immune system (HIV infection, cancer, chemotherapy, leukemia, chronic steroid treatment, asplenia, organ transplant) ▪ Contact with others that have severely weakened immune systems being cared for in a protective environment (e.g. people with hematopoietic stem cell transplants) ▪ Condition requiring long-term aspirin therapy and I am between the ages 6 months-18 years old 	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am pregnant, breastfeeding or lactating	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. I have received antiviral medication for influenza in the last 2 days or may receive antiviral medication for influenza in the next 2 weeks	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. I have received the seasonal influenza vaccine this year Mark which type and fill in date received: <input type="checkbox"/> Spray <input type="checkbox"/> Shot Date received: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes
7. I have received the H1N1 (Swine Flu) vaccine this year Mark which type and fill in date received: <input type="checkbox"/> Spray <input type="checkbox"/> Shot Date received: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes

Vaccine/Manufacturer	Route and Dose	Site	Lot Number	Date VIS Given	VIS Date
<input type="checkbox"/> H1N1 MedImmune	<input type="checkbox"/> 0.2 mL-1.0 mL/nosril	<input type="checkbox"/> NAS			10/1/09
<input type="checkbox"/> H1N1 Novartis	<input type="checkbox"/> 0.25 mL PF	<input type="checkbox"/> RD			
<input type="checkbox"/> H1N1 Sanofi	<input type="checkbox"/> 0.5 mL PF	<input type="checkbox"/> LD			
<input type="checkbox"/> H1N1 CSL	<input type="checkbox"/> 0.5 mL	<input type="checkbox"/> RVL			
<input type="checkbox"/> H1N1 GSK		<input type="checkbox"/> LVL			

Administered by: _____ Date: _____

