



## Screening Questionnaire for Intranasal Influenza Vaccination

Pediatric & Adult Medicine, Inc.

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Chart # \_\_\_\_\_

Form Completed by \_\_\_\_\_ Date \_\_\_\_\_

- |   | Yes                      | No                       | Don't Know               |
|---|--------------------------|--------------------------|--------------------------|
| 1. Is the person to be vaccinated sick today?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist®) in the past?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is the person to be vaccinated younger than age 2 or older than 49 years?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorders?                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or other disease that affects the immune system, long-term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Is the person to be vaccinated receiving aspirin therapy aspirin-containing therapy?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Is the person to be vaccinated pregnant or could she become pregnant within the next month?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has the person to be vaccinated ever had Guillain-Barré syndrome?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Does the person to be vaccinated live with or expect to have close contact with any person whose immune system is severely compromised and who must be in a protective environment (such as a hospital room).                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has the person to be vaccinated received any other vaccines in the past 4 weeks?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Form reviewed by \_\_\_\_\_ Date: \_\_\_\_\_

Vaccine to be given     Seasonal     Already Given     H1N1     Already Given

Technical content reviewed by the Centers for Disease Control and Prevention  
Immunization Action Coalition



## Cuestionario previo a la Vacunacion Intranasal contra Influenza

Pediatric & Adult Medicine, Inc.

Nombre del Paciente \_\_\_\_\_ Fecha de Nacim \_\_\_\_\_ Archivo # \_\_\_\_\_

Forma preparada por \_\_\_\_\_ Fecha \_\_\_\_\_

- |   | Si                       | No                       | No se                    |
|---|--------------------------|--------------------------|--------------------------|
| 1. Esta enferma la persona a vacunar hoy?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. La persona a vacunar tiene alergia a los huevos o algun compuesto de la vacuna de influenza?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. La persona a vacunar algun vez tuvo una reaccion adversa a la vacuna de influenza (FluMist) en el pasado?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Es la persona a vacunar menor de 2 años o mayor de 49?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. La persona a vacunar, tiene algun problema con enfermedad del corazon, pulmones, asma, riñon, diabetes, anemia u otras enfermedades de la sangre?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Si la persona a vacunar es un niño de 2 a 4 años, en los ultimos 12 meses algun Doctor le dijo que tenia dificultad para respirar o asma?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Tiene la persona a vacunar una disminucion de su sistema inmunologico debido a HIV/SIDA o alguna otra enfermedad que afecte el sistema inmunologico, tratamiento a largo plazo de drogas como esteroides o tratamiento de cancer con rayos X o drogas? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Esta la persona a vacunar recibiendo terapia basada en aspirinas o conteniendo aspirina?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Esta la persona a vacunar embarazada o podria quedar embarazada en el mes proximo?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. La persona a vacunar alguna vez tuvo el Sindrome de Guillain-Barre?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. La persona a vacunar vive con o espera tener contacto cercano con cualquier persona cuyo sistema inmunologico esta severamente comprometido y que tiene que estar en un ambiente protegido (habitacion de hospital)                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ha recibido la persona a vacunar alguna otra vacuna en las ultimas 4 semanas?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Form reviewed by \_\_\_\_\_ Date: \_\_\_\_\_

Vaccine to be given  Seasonal  Already Given  H1N1  Already Given

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