TB and Influenza Vaccine Questionaire

How did you hear about us?

❍ Patient ❍ School ❍ Employer ❍ Doctor ❍ Insurance ❍ Online ❍ Signage

❍ Other, please describe: ____________________

Social Security Number: ____________________ **Sex:** ❍ Male ❍ Female

Last Name: ________________ **First Name:** ________________ **MI:** _____

Address: ________________________________ **Apt:** ______________

City: ______________ **State:** _____ **Zip:** ________ **Home Phone:** ____________

Cell Phone: ________________ **Email:** ______________________________

Preferred Method of Contact: ❍ Home ❍ Cell ❍ Email

Marital Status: ❍ Single ❍ Married ❍ Divorced ❍ Widowed ❍ Separated

Race: ❍ Native American ❍ Asian ❍ Black / African ❍ Pacific Islander ❍ White ❍ Decline

Ethnicity: ❍ Hispanic / Latino ❍ Not Hispanic ❍ Decline **Preferred Language:** ____________

Screening Questionaire

The following questions will help us determine if there is any reason we should not give you or your child the injectable influenza or TB test today. If a question is not clear, please ask your healthcare provider for clarification.

Please list any known allergies that you have: ______________________________

Flu Vaccine Questionnaire

1. Is the person to vaccine pregnant?	❍ Yes	❍ No	❍ Unsure
2. Is the person to be vaccinated sick today?	❍ Yes	❍ No	❍ Unsure
3. Does the person to be vaccinated have an allergy to eggs or any component of the vaccine?	❍ Yes	❍ No	❍ Unsure
4. Has the person to be vaccinated ever had a serious reaction to an influenza vaccine in the past?	❍ Yes	❍ No	❍ Unsure
5. Has the person to be vaccinated ever had Guillian-Barré syndrome?	❍ Yes	❍ No	❍ Unsure

TB Test Questionnaire

1. Are you pregnant?	❍ Yes	❍ No
2. Are you taking steroids or cancer medication?	❍ Yes	❍ No
3. Have you ever tested positive for TB?	❍ Yes	❍ No
4. Have you received a live virus vaccine within the last two months (i.e. MMR, Varicella)?	❍ Yes	❍ No

YOU MUST RETURN TO HAVE YOUR TB TEST READ BETWEEN 48 & 72 HOURS AFTER IT WAS

I understand the facts about the influenza vaccine, tuberculosis, and the skin test stated above. I understand that payment is due at the time are rendered. Failing to return for TB Test reading as specified will void the test and require a new one.

Patient/Guardian Signature: ______________________________ **Date:** ______________

FOR OFFICE USE ONLY

Med: ______________ Exp. Date: ___________ Dose: ____________ Lot #: ________

Location: ____________ Date Administered: __________ Time Administered: ________

Administering Nurse Initials: _________

Read by: ___________ Induration _____mm

TB Test Results: Pos / Neg Date Read: __________ Positive results reviewed ______