Baylor Scott & White HEALTH

Flu Vaccine Questionnaire 2017

New Patient: □ Yes □ No
Clinic Name: _____
PCP: _____

Patient's Last Name:_____ **First:** _____

Gender: □M □F **Date of Birth:** ___/___/____ **Age:** _____ **Daytime Phone:** (___) ____-_____

Current Mailing Address: _____**City**_____**State**_____ **Zip**_____

Medical Insurance (Mark X in one or more boxes that apply):

❑ **Medicare:**
Policy Number: _____

❑**Commercial Insurance**:
Insurance: _____
Policy Number: _____
Grp Number: _____
Primary Insured: _____

❑**Medicaid/Texas Vaccines for Children Program**:
❑Medicaid Number: _____ Date of Eligibility: _____
OR ❑CHIP Number: _____ Date of Eligibility: _____
OR ❑American Indian **OR** Alaska Native
OR ❑Is **underinsured***: **(Mark X in one of boxes below)**
❑My child's commercial (private) insurance, but coverage does **not** include vaccines **OR**
❑My commercial insurance covers only selected vaccines

❑**Self-Pay/Uninsured Options:**
Cash Payment: ❑**$**_____ **amount**
Credit Card: ❑ **Visa** ❑ **MC** ❑ **Discover** ❑ **Am Expr**
**Please provide card to attendant for processing. A receipt will be provided.*
Name on Card:_____

Billing Address:
_____

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If you answer any of the following questions "YES", you may not be eligible for flu vaccine today.

1. Has the flu vaccination already been received this season?	**Yes**	**No**
2. Have you/your child ever had a serious reaction/sensitivity to any flu vaccine?	**Yes**	**No**
3. Have you/your child ever been diagnosed with severe muscle pains and paralysis (Guillain-Barre' syndrome) within 6 weeks after receiving a flu vaccine?	**Yes**	**No**
4. Do you/your child have a severe allergy to eggs (chest pain, Symptomatic rapid heartbeat, wheezing, requires epinephrine)?	**Yes**	**No**
5. Less than 6 months of age?	**Yes**	**No**
6. Bone marrow transplant within the past 6 months?	**Yes**	**No**
7. Are you/your child allergic to LATEX? (Found in injection syringes, gentamicin sulfate, Gelatin or MSG?)	**Yes**	**No**
8. Have you felt ill today or yesterday or do you have a fever?	**Yes**	**No**
9. Do you/your child have anemia or a serious blood disorder?	**Yes**	**No**
10. Have you/your child received any live vaccines in the past 4 weeks?		
E.g.: MMR, Chicken Pox or Zostovax (Shingles)	**Yes**	**No**
If yes, which one/s:_____ Date/s given:_____		
11. **FEMALE ONLY**: Are you currently pregnant?	**Yes**	**No**
If yes: Which trimester? 1st 2nd 3rd		

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Patient/Parent Signature _____ **Date**_____

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For office use (Circle One): FLULAVAL QUAD FLUZONE QUAD

Administered by _____ **Date**_____ **Time**_____

Lot No. _____ GSK Sanofi **Expiration date** _____ **VIS Sheet given?** **Yes** **No**

Site of Injection R L deltoid thigh **Patient MRN**:_____ **EMR Entry Name**: _____