Patient name:_____ Date of birth: _____/_____/____
(mo.) (day) (yr.)

Screening Questionnaire for Intranasal Influenza Vaccination

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child intranasal influenza vaccine (FluMinst) today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist) in the past?	☐	☐	☐
4. Is the person to be vaccinated younger than age 2 years or older than 49 years?	☐	☐	☐
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?	☐	☐	☐
6. Has the person to be vaccinated ever been diagnosed with asthma, ever been told by a doctor that they were wheezing or been prescribed an inhaler or nebulizer?	☐	☐	☐
7. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affect the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	☐	☐	☐
8. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	☐	☐	☐
9. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	☐	☐	☐
10. Has the person to be vaccinated ever had Guilain-Barre' syndrome?	☐	☐	☐
11. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective isolation (such as in a hospital room with reverse air flow)?	☐	☐	☐
12. Has the person to be vaccinated received MMR, Varivax (chicken pox) vaccine, yellow fever or shingles vaccine <u>in the last four weeks?</u>	☐	☐	☐

Form completed by:_____ Date:_____
Form completed by:_____ Date: _____