# 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. | ☐ Yes ☐ 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 | ☐ Yes ☐ No |
| 3. I have one of the following conditions or chronic illnesses:<br>▪ Diabetes, heart problems, kidney problems,<br>▪ Lung problems, including asthma<br>▪ History of recurrent or active wheezing, under the age of 5 years<br>▪ Conditions that make it difficult to keep the airway clear (spinal cord injuries, paralysis, seizure disorders, neuromuscular disorders, cognitive disorders)<br>▪ History of Guillian-Barré Syndrome; conditions that affect the immune system (HIV infection, cancer, chemotherapy, leukemia, chronic steroid treatment, asplenia, organ transplant)<br>▪ Contact with others that have severely weakened immune systems being cared for in a protective environment (e.g. people with hematopoietic stem cell transplants)<br>▪ Condition requiring long-term aspirin therapy and I am between the ages 6 months-18 years old | ☐ Yes ☐ No |
| 4. I am pregnant, breastfeeding or lactating | ☐ Yes ☐ 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 | ☐ Yes ☐ No |
| 6. I have received the seasonal influenza vaccine this year<br>Mark which type and fill in date received: ☐ Spray ☐ Shot Date received:_____ | ☐ Yes ☐ No<br>**If Yes** ↵ |
| 7. I have received the H1N1 (Swine Flu) vaccine this year<br>Mark which type and fill in date received: ☐ Spray ☐ Shot Date received:_____ | ☐ Yes ☐ No<br>**If Yes** ↵ |

*For Office Use Only* *Clinic Name:* *Address:*

| Vaccine/Manufacturer | Route and Dose | Site | Lot Number | Date VIS Given | VIS Date |
|---|---|---|---|---|---|
| ☐ H1N1 MedImmune<br>☐ H1N1 Novartis<br>☐ H1N1 Sanofi<br>☐ H1N1 CSL<br>☐ H1N1 GSK | ☐ 0.2 mL-1.0 mL/nostril<br>☐ 0.25 mL PF<br>☐ 0.5 mL PF<br>☐ 0.5 mL | ☐ NAS<br>☐ RD<br>☐ LD<br>☐ RVL<br>☐ LVL | | | 10/1/09 |

Administered by: _____ Date: _____

Washington State Department of Health

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