Questionnaire for vaccination

Date of vaccination ______ / ______ / ______
Month Day Year

Name : ______________________ Sex: M ・ F

Date of birth: ______ / ______ / ______ Company name: ______________
Month Day Year

Health insurance association name: ______________ (Number －)

Adress: 〒 －

____

Phone number: ______________________ (home ・ mobile)

Please answer the following questions.

1) What kind of vaccination have you ever have ?

Name of vaccination(s)

____

2) Have you received vaccination within the past four weeks? Yes / No

3) Have you been sick within the past four weeks? Yes / No

4) Have you ever diagnosed as having an immunodeficiency disease? Yes / No

5) Are you allergic to any food or medicine? Yes / No

Name of allergic reagent(s)

____

6) Are you currently under medication? Yes / No

Name of medicine

____

7) Do you currently have , or have had in the past, any of the Following diseases? Yes / No

Heart disease ・ kidney disease ・ liver disease ・ hematological disease ・ others

Name of disease

____

8) Have you ever had convulsions? Yes / No

9) Are you feeling well today? Yes / No

If you feel not so well, describe how you feel now.

____

10) Measure your body temperature at this place and write it here. ______ ℃

11) Are you currently pregnant? Is there any possibility that you are pregnant? Yes / No

(only for women)

Reading the notes about influenza vaccination, I agree to get a vaccination .

Signature ______________________

Office use only

Fit ・ Unfit

Doctor' s signature ______________

LOT.No. ______________ Production date ______ / ______ / ______

0.25ml ・ 0.5ml