LANE END MEDICAL GROUP
FLU VACCINATION QUESTIONNAIRE

Name ……..

Date of Birth …… Age ……
Please write your mobile number below if you would like us to text your appointment reminders to you
……

Are you allergic to anything? ……

Have you had a flu vaccination before? **YES NO**

If so, when was the last time? ……..

Did you have any side-effects? **YES NO**

If so, what were they? ……

Have you had any other vaccinations in the last 3 months? **YES NO**

If so, which ones? ……

Are you well at the moment? **YES NO**

Are you taking any medication? **YES NO**

If your answer is 'yes' please list below what you are taking?
……

……
WOMEN OF CHILD BEARING AGE ONLY:-
Date of your last period ……..

FOR NURSES ONLY:-

DATE …… MANUFACTURER ……

VACCINE …… BATCH NO…… EXP DATE……