



# TB AND INFLUENZA VACCINE QUESTIONNAIRE

2507 Eastbluff Drive  
Newport Beach, CA 92660  
Ph: 949-200-1655 Fx: 949-200-1650

**How did you hear about us?**  Referred by Patient  Referred by: School Employer Doctor Insurance  
 Online (circle one): Google, Facebook, Yahoo, Yelp, other \_\_\_\_\_  Signage  Other Source: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Sex (circle one): Male / Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ Apt# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Would you like to receive informational emails?  Yes  No

Preferred method of contact:  Home Phone  Cell Phone  Email

**Marital Status:** Single Married Divorced Widowed Separated  
**Race:** American Indian Asian Black/African American Native Hawaiian/Pacific Islander White Decline  
**Ethnicity:** Hispanic/Latino Not Hispanic Decline **Preferred Language:** \_\_\_\_\_

### Screening Questionnaire

The following questions will help us determine if there is any reason we should not give you or your child the injectable influenza or TB test today. If a question is not clear, please ask your healthcare provider for clarification.

**Please list any known allergies that you have:** \_\_\_\_\_

### Flu Vaccine Questionnaire

1. Is the person to vaccinate pregnant? Yes  No  Unsure
2. Is the person to be vaccinated sick today? Yes  No  Unsure
3. Does the person to be vaccinated have an allergy to eggs or any component of the vaccine? Yes  No  Unsure
4. Has the person to vaccinated ever had a serious reaction to influenza vaccine in the past? Yes  No  Unsure
5. Has the person to be vaccinated ever had Guillian-Barré syndrome? Yes  No  Unsure

### TB Test Questionnaire

1. Are you pregnant? Yes  No
2. Are you taking steroids or cancer medication? Yes  No
3. Have you ever tested positive for TB? Yes  No
4. Have you received a live virus vaccine within the last two months (i.e. MMR, Varicella)? Yes  No

**YOU MUST RETURN TO HAVE YOUR TB TEST READ BETWEEN 48 & 72 HOURS AFTER IT WAS PERFORMED**

I understand the facts about the influenza vaccination, tuberculosis, and the skin test stated above. I understand that payment is due at the time services are rendered. Failing to return for TB Test reading as specified will void test and require a new one.

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### FOR OFFICE USE ONLY

Med: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ Dose: \_\_\_\_\_  
Lot #: \_\_\_\_\_ Location: \_\_\_\_\_ Date Administered: \_\_\_\_\_  
Time Administered: \_\_\_\_\_ : \_\_\_\_\_ am / pm Administering Nurse Initials: \_\_\_\_\_

TB TEST RESULTS: Positive ( ) or Negative ( ) Read by: \_\_\_\_\_ Date Read: \_\_\_\_\_

Induration \_\_\_\_\_ mm Positive results Reviewed \_\_\_\_\_