REGION SÖRMLAND

Influenza vaccination questionnaire

Patient details:

Name ____________________ Personal ID number ____________________

Before your flu vaccination, please answer the following questions:

1. Are you currently suffering from a fever and/or an acute infection? Yes ☐ No ☐
2. Have you previously had any problems with vaccinations? Yes ☐ No ☐
3. Are you allergic to egg? Yes ☐ No ☐
4. Have you suffered anaphylaxis (severe allergic reaction) caused by egg? Yes ☐ No ☐
5. Do you have any other serious allergies? Yes ☐ No ☐
6. Do you regularly take any anticoagulants, such as Waran, Fragmin, Pradaxa, Xarelto or Eliquis? (Trombyl is okay) Yes ☐ No ☐
7. Are you in a medical risk group, such as: Yes ☐ No ☐
   - Chronic heart, lung or kidney disease
   - Chronic lung disease, COPD or severe asthma
   - Diseases that cause impaired lung function or impaired cough capacity
   - Unstable blood sugar (diabetes mellitus)
   - Severely reduced immunity to infection, such as due to chemotherapy.
8. Are you at least 16 weeks pregnant and not in any of the above groups? Yes ☐ No ☐
9. Each autumn, you can receive a text message reminding you that it is time for your flu vaccine. Would you like to know more? Yes ☐ No ☐
10. Do you work closely with patients within healthcare in Region Sörmland? Yes ☐ No ☐

Name:____________________ Signature: ____________________

The following section will be completed by the vaccination clinic

Vaccinationsdatum:	Ordinatörens namn:
Vaxigrip Tetra ☐	Annat vaccin namn:
Administreringssätt: Hö arm ☐ i.m. ☐ s.c. ☐	Vä arm ☐ i.m. ☐ s.c. ☐
Batch-/lotnummer:	Ev. annan lokalisation för administrering:
Ev. kommentar:	
Vaccinationen är registrerad i Svevac ☐	Registrerad i Svevac som personalvaccination ☐