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 ____ - ____)

Phone number: _____ (home ・ mobile)

Please answer the following questions

1) What kind of vaccination would you like to have ? Yes / No

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) Is it within 4 weeks after your new coronavirus infection is cured? Yes / No

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

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

Name of allergic reagent(s)

_____

7) Are you currently under medication? Yes / No

Name of medicine

_____

8) 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

_____

9) Have you ever had convulsions? Yes / No

10) Are you feeling well today? Yes / No

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

_____

11) Measure your body temperature at this place and write it here. ____ ℃

12) 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