Patient Assessment Form -**INFLUENZA (2 Pages)**

Name: _____ Date of Birth (mm/dd/yyyy): _____ Age: _____ Visit Date:_____(mm/dd/yyyy)

Need help with this form? It's common for people to ask!
We're happy to go through the questions with you—just let us know.

PATIENT MEDICAL INFORMATION	
Medical Provider:	Practice Name and phone number:
Medication Allergies? (List name of medication(s) and your reaction to them)	
Current Medication(s)? (prescription, over-the counter, herbals, topical medications, pain or allergy medication, and any supplements/vitamins): _____ _____ _____ _____ _____	
Treatments tried for current condition (If none, please indicate N/A)	

PATIENT ELIGIBILITY (Legal Guardian may respond on behalf of patient)		
1. Do you have any of these symptoms which are sometimes caused by the flu? (check all that apply)	☐Fever ☐Muscle/body aches ☐Headache ☐Cough ☐Sore throat ☐extreme tiredness ☐Other _____ ☐ I HAVE NO SYMPTOMS	
2. When did these symptoms start? If you have no symptoms, when were you exposed to a person with the flu?	☐More than 2 days ago ☐2 days ago, yesterday, or today	
3. Are you Pregnant or Breastfeeding?	☐Yes	☐No
4. Are you currently receiving treatment for cancer, such as chemotherapy or radiation? This includes treatment for blood cancers like leukemia, lymphoma, or multiple myeloma. If YES, please explain: _____ _____ _____	☐Yes	☐No
5. Have you ever had an organ or stem cell transplant and are you currently taking medications to prevent your body from rejecting it? If YES, please explain: _____ _____ _____	☐Yes	☐No
6. Has a doctor ever told you that you have a weakened immune system due to a condition you were born with such as DiGeorge syndrome, Wiskott-Aldrich syndrome or Bruton Disease?	☐Yes	☐No
7. Have you been taking medications that weaken the immune system, like steroids (such as prednisone) for more than 2 weeks?	☐Yes	☐No
8. Do you have sickle cell anemia?	☐Yes	☐No
9. Have you ever been diagnosed with HIV or AIDS?	☐Yes	☐No
10. Do you use oxygen at home or need extra oxygen to help you breathe?	☐Yes	☐No

➞ Flip this page over — more questions on the back!

11. Are you 19 years of age or younger and taking aspirin every day or on a regular basis for a health condition?	☐Yes	☐No
12. Has your doctor ever told you that you have kidney problems, or kidney disease, but that you don't need dialysis?	☐Yes	☐No
13. Has your doctor ever told you that you have breathing problems, such as asthma, COPD, or cystic fibrosis?	☐Yes	☐No
14. Has your doctor ever told you that you have heart problems such as heart disease, heart failure, blocked arteries or problems with blood flow to your heart?	☐Yes	☐No
15. Do you have diabetes?	☐Yes	☐No
16. Are you of American Indian or Alaska Native descent?	☐Yes	☐No
17. Have you received the influenza vaccine FluMist® Nasal Spray in the last 2 weeks?	☐Yes	☐No
18. Have you ever had an allergic reaction to medicine used to treat the flu? For example, did you have trouble breathing, a rash, or swelling after taking flu medicine like oseltamivir (Tamiflu®)?	☐Yes	☐No
19. Have you ever had any side effects after taking flu medicine in the past? (like nausea, vomiting, diarrhea, abdominal pain, dizziness, difficulty breathing, wheezing)	☐Yes	☐No
20. Are you on dialysis, or has your doctor ever told you that you have kidney failure?	☐Yes	☐No
21. Have you taken medicine for the flu in the last 4 weeks? (like Tamiflu or another antiviral)?	☐Yes	☐No

Comments:

(Please use this space to write any extra information or notes you want the pharmacist to know.)

Patient Attestation Form Influenza

What You're Agreeing To:

By signing this form, you are saying that you understand and agree to the following:

- I have flu-like symptoms (like a fever, cough, sore throat, body aches, or feeling very tired), or I have been around someone with the flu and want to be checked to see if I should take medicine to help prevent or treat it.
- A licensed pharmacist will ask me about my symptoms and health history. If I qualify, the pharmacist will do a quick flu test using a nose swab.
- The pharmacist will use this information to decide what to do next.
- If I need a flu test, the pharmacist will review my test results and how I am feeling and may:
    - Give me medicine to treat the flu, or
    - Tell me to go to a doctor's office, urgent care, or emergency room if I need more help.
- I understand that flu medicine works best if taken early. It can help me feel better faster and make my symptoms less severe.
- If I start to feel worse, don't get better, or have side effects from the medicine, I will contact my regular doctor.
- I know it's important to have a regular doctor. If I don't have one, I can ask the pharmacist to help me find one.

Consent:

- I give permission for the pharmacist to test me for the flu, check my symptoms, and give me treatment if needed.
- I understand the pharmacist is allowed to do this under state-approved rules.
- I understand this visit will be written down and shared with my doctor.

_____ _____

Patient Name Date of Birth

_____ _____

Patient/Parent or legal Guardian Signature Date