

## 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: |
| 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):                                                                                                                                                                                                                                                                                              |                |
| <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 5px;"></div> |                |
| Treatments tried for current condition (If none, please indicate N/A)                                                                                                                                                                                                                                                                                                                                                                         |                |

| PATIENT ELIGIBILITY<br>(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)                                                                                                               | <input type="checkbox"/> Fever<br><input type="checkbox"/> Muscle/body aches<br><input type="checkbox"/> Headache<br><input type="checkbox"/> Cough<br><input type="checkbox"/> Sore throat<br><input type="checkbox"/> extreme tiredness<br><input type="checkbox"/> Other _____<br><input type="checkbox"/> 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?                                                                                                       | <input type="checkbox"/> More than 2 days ago<br><input type="checkbox"/> 2 days ago, yesterday, or today                                                                                                                                                                                                                        |                             |
| 3. Are you Pregnant or Breastfeeding?                                                                                                                                                                            | <input type="checkbox"/> Yes                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> 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.<br>If YES, please explain: _____ | <input type="checkbox"/> Yes                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> 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?<br>If YES, please explain: _____                                          | <input type="checkbox"/> Yes                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> 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?                                | <input type="checkbox"/> Yes                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> No |
| 7. Have you been taking medications that weaken the immune system, like steroids (such as prednisone) for more than 2 weeks?                                                                                     | <input type="checkbox"/> Yes                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> No |
| 8. Do you have sickle cell anemia?                                                                                                                                                                               | <input type="checkbox"/> Yes                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> No |
| 9. Have you ever been diagnosed with HIV or AIDS?                                                                                                                                                                | <input type="checkbox"/> Yes                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> No |
| 10. Do you use oxygen at home or need extra oxygen to help you breathe?                                                                                                                                          | <input type="checkbox"/> Yes                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> No |
| → Flip this page over — more questions on the back!                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                  |                             |

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| 11. Are you 19 years of age or younger and taking aspirin every day or on a regular basis for a health condition?                                                                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Has your doctor ever told you that you have kidney problems, or kidney disease, but that you don't need dialysis?                                                                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Has your doctor ever told you that you have breathing problems, such as asthma, COPD, or cystic fibrosis?                                                                                         | <input type="checkbox"/> Yes | <input type="checkbox"/> 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?                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Do you have diabetes?                                                                                                                                                                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Are you of American Indian or Alaska Native descent?                                                                                                                                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Have you received the influenza vaccine FluMist® Nasal Spray in the last 2 weeks?                                                                                                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> 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®)? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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)                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 20. Are you on dialysis, or has your doctor ever told you that you have kidney failure?                                                                                                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 21. Have you taken medicine for the flu in the last 4 weeks? (like Tamiflu or another antiviral)?                                                                                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> 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.

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Patient Name

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Date of Birth

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Patient/Parent or legal Guardian Signature

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Date