LIFESTYLE CHECK

Complete on the Day of your Flu Vaccination	Yes	No
1. Are you in normal health at present?	☐	☐
2. Do you have any allergies?	☐	☐
3. Are you Pregnant or breast feeding? Not applicable ☐	☐	☐
4. Do you have any illness that may affect your immune system?	☐	☐
5. Are you on chemotherapy or steroid tablets?	☐	☐
6. Are you allergic to antibiotics?	☐	☐
7. Have you ever had any reaction to any previous vaccinations?	☐	☐

If the answer to the above is Yes, please list which drug(s) you are allergic to:

.....

Name: .....

Address: .....

.....

DOB: .....

I consent to receiving a Flu Vaccine – signed _____

Date _____

Smoking Status Please **circle your answer**

Never Smoked Ex-smoker Current Smoker I smoke _____cigarettes per day.

If you are a smoker the practice can offer you advice.

Would you like to stop smoking YES or NO if your answer is **YES** contact the Practice.

Practice Use Only

ADMINISTER FLU VACCINATION

Please circle which arm R OR L

BATCH NUMBER _____

Signed by GP/NURSE: _____ **Date** _____