



3998 MAIN STREET (@ 24TH) • VANCOUVER • BC • V5V 3P2

MEDICAL: (604)873-3666

• FAX: (604)875-8790 •

WWW.MIDMAIN.NET

2020/21 Flu Vaccine Patient Questionnaire

Dear Patient,

Prior to your flu shot appointment, please complete and return this questionnaire to midmain.notifications@gmail.com or fax to **604-875-8790**.

Patient's Name: _____ Date of Birth: ____ / ____ / ____
MM DD YYYY

Phone Number: _____ Email: _____

****Please provide your contact information in case we need further information****

1. Have you had the flu vaccine in the past? Yes No
2. Have you had a previous reaction to the flu vaccine? Yes No
3. Allergy to eggs? Yes No
4. Allergy to thimerosal? Yes No
5. Any vaccines in the past 4-6 weeks? Yes No
6. Any current illness/fever? Yes No
7. If you are 65 years or older, immunocompromised, or have a chronic illness, you are eligible for the pneumonia shot. Would you like to receive the pneumonia shot? Yes No
8. When was your last pneumonia shot? _____

or FAX to 604-875-8790