

PATIENT ASSESSMENT FORM: INFLUENZA



PATIENT INFORMATION

Full Name (First MI Last): _____ Date of Birth: _____ Age: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Email: _____ Phone: _____

MEDICAL INFORMATION

Primary Care Doctor: _____ Practice Name: _____ Phone: _____
 List any medication allergies, including name of medication and reaction to them.

 List current prescriptions and supplements, including over-the-counter, herbals, topicals, allergy or pain medications, and vitamins.

 List treatments tried for current condition. If none, please indicate N/A.

SCREENING QUESTIONS

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 Fatigue Other: _____ I HAVE NO SYMPTOMS

When did these symptoms start? If you have no symptoms, please state when you were exposed to a person with the flu.

More than 2 days ago 2 days ago, yesterday or today

	YES	NO	Don't Know or N/A
Are you pregnant or breastfeeding?			
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: _____			
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: _____			
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?			
Have you been taking medications that weaken the immune system, like steroids for more than two weeks?			
Do you have sickle cell anemia?			
Have you ever been diagnosed with HIV or AIDS?			
Do you use oxygen at home or need extra oxygen to help you breathe?			
Are you 19 years of age or younger and taking aspirin every day or on a regular basis for a health condition?			
Has your doctor ever told you that you have kidney problems, or kidney disease, but that you didn't need dialysis?			
Has your doctor ever told you that you have breathing problems, such as asthma, COPD or cystic fibrosis?			
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?			
Do you have diabetes?			
Are you American Indian or Alaska Native descent?			
Have you received the influenza vaccine FluMist® Nasal Spray in the last two weeks?			
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®)?			
Have you ever had any side effects after taking flu medicine in the past - including nausea, vomiting, diarrhea, abdominal pain, dizziness, difficulty breathing, wheezing?			
Are you on dialysis, or has your doctor ever told you, that you have kidney failure?			
Have you taken medicine for the flu in the past four weeks?			

ADDITIONAL COMMENTS

SIGNATURE OF PATIENT TO RECEIVE INFLUENZA TEST

(or Signature of Power of Attorney or Legal Guardian) _____ Date: _____

Guardian/ Guarantor Name: _____ Relationship to patient: _____



PATIENT ATTESTATION FORM: **INFLUENZA**

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

- I have flu-like symptoms (such as fever, cough, sore throat, body aches, fatigue), 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 (anti-viral) 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: _____

Guardian/ Guarantor Name Signature: _____ Today's Date: _____

Relationship to patient: _____