Advanced Radiology Services PC

Flu Vaccine Questionnaire

Patient Name: ____
Date of Birth: ____________________
Today's Date: ____________________

Have you had an influenza vaccine: ☐ Yes ☐ No

If yes, date of influenza vaccine: _____________________________________

If no, reason why: _____________________________________

Have you had a pneumonia vaccine: ☐ Yes ☐ No

If yes, date of pneumonia vaccine: ____

If no, reason why: _____________________________________

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