ACUTE INFLUENZA INFECTION ANTIVIRAL THERAPY

PATIENT INFORMATION *(Please print clearly)*

Last Name:	**First Name:**	**D.O.B.:**	**Age:**	**Gender:**	**Height:**	**Weight:**
Home Address:			Contact Phone:			
City:			State:		Zip:	
Primary Care Physician:			Physician Phone:			
Physician Address:			Physician Fax #:			
Please state any past medical history and chronic conditions:						
Current medications:						
Allergies (please state reaction that occurs when exposed to the allergen):						

SCREENING QUESTIONNAIRE

	Yes	**No**	**Don't Know**
Are you experiencing any of the following symptoms: fever, muscle pain, weakness, headache, sore throat, dry cough, rhinitis, nasal congestion?	☐	☐	☐
Did your symptoms start in the past 48 hours?	☐	☐	☐
Have you had an Influenza virus infection confirmed by Rapid Influenza Diagnostic Test?	☐	☐	☐
For women: Are you currently pregnant or breastfeeding?	☐	☐	☐
Do you have history of kidney dysfunction?	☐	☐	☐
Do you currently have a condition such as cancer, leukemia, hematologic malignancy or HIV/AIDS that weakens your immune system?	☐	☐	☐
Are you currently on long term aspirin or aspirin containing therapy? (19 years of age and younger only)	☐	☐	☐
Are you currently taking cortisone, prednisone, other steroids, anticancer drugs or had any radiation treatment?	☐	☐	☐
Are you currently on antiviral medication or been prescribed it in the last 2 weeks?	☐	☐	☐
Do you use home oxygen therapy?	☐	☐	☐
Do you have a history of asthma or other respiratory disease? (For Zanamivir only)	☐	☐	☐
Have you had any prior intolerance to Fructose of Sorbitol? (For Oseltamivir only)	☐	☐	☐
Have you ever had a reaction to Oseltamivir, Zanamivir or other antiviral agents in the past? *If so, what was the reaction:*	☐	☐	☐
Are you experiencing any of the following symptoms: Altered mental status, low blood pressure, increased heart rate, increased breathing rate, fever?	☐	☐	☐