ACUTE INFLUENZA INFECTION CHEMOPROPHYLAXIS

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
Do you have a family member who has been diagnosed with Influenza?	☐	☐	☐
Have you been in close contact with individuals with possible or confirmed Influenza infection?	☐	☐	☐
Have you been exposed to individuals with possible or confirmed Influenza infection in the last 48 hours?	☐	☐	☐
Have you received a vaccination for Influenza in the past? *If yes, when:*	☐	☐	☐
Are you currently on long term aspirin or aspirin-containing therapy? (19 years of age and younger only)	☐	☐	☐
Have you been diagnosed with Chronic Obstructive Pulmonary Disease (COPD)?	☐	☐	☐
Have you been diagnosed with Asthma or any other respiratory disease?	☐	☐	☐
Do you currently have a condition such as cancer, leukemia, or HIV/AIDS that weakens your immune system?	☐	☐	☐
Are you currently taking cortisone, prednisone, other steroids, anticancer drugs or had any radiation treatment?	☐	☐	☐
For women: Are you currently pregnant or considering becoming pregnant in the next month?	☐	☐	☐
Have you had a serious reaction to Oseltamivir (Tamiflu) or Zanamivir (Relenza) in the past?	☐	☐	☐
Do you have a history of kidney dysfunction?	☐	☐	☐
Have you had any prior intolerance to Fructose or Sorbitol?	☐	☐	☐