

INFLUENZA VACCINATION MEDICAL QUESTIONNAIRE

Temperature before vaccination (診察前体温) _____ °C

Address (住 所)	TEL		
Name of recipient (受ける人の氏名)	Sex (性別) <input type="checkbox"/> Male (男) <input type="checkbox"/> Female (女)	Date of birth (生年月日)	(Year 年 Mo 月 Day 日) / /
Name of guardian (保護者の氏名)			

Questions (質問事項)	Answers(回答)		Physician's column
1. Do you understand the effect and reactions from today's vaccination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2. Is this influenza vaccination first time in this season? 今シーズン初めてのインフルエンザワクチン?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3. Are you currently feeling unwell? 今、具合の悪いところがありますか。 Symptoms (症状): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4. Do you currently consult a doctor for any diseases? 現在の病気 Disease names (病名): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has the attending physician said it is okay to receive today's vaccination? その病気の主治医には、今日の予防接種を受けてよいといわれましたか。	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5. Have you a fever or been sick within the past month? 最近1カ月以内の熱、病気 Disease names (病名): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6. Within the past month, have any of your friends or family members had influenza, measles, rubella, chicken pox, or mumps? 最近1ヶ月以内に、家族や遊び仲間に、インフルエンザ、麻疹(はしか)、風しん、水痘、おたふくかぜなどの病気の方がいましたか。	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7. Have you been vaccinated within the past month? 最近1ヶ月以内の予防接種 Type of vaccine (予防接種の種類) <input type="checkbox"/> BCG <input type="checkbox"/> Polio ポリオ <input type="checkbox"/> Diphtheria ジフテリア <input type="checkbox"/> Pertussis 百日せき <input type="checkbox"/> Tetanus 破傷風 <input type="checkbox"/> Measles 麻疹(はしか) <input type="checkbox"/> Rubella 風しん <input type="checkbox"/> Japanese encephalitis 日本脳炎	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8. Have you ever become ill after being vaccinated for anything? これまでに予防接種を受けて具合が悪くなったことがありますか。	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
9. Have you ever been diagnosed with an immunodeficiency or any chronic heart, kidney, liver, or blood diseases? 心臓病、腎臓病、肝臓病、血液疾患などの慢性疾患にかかったことがありますか。 Disease names (病名): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has the attending physician said it is okay to receive today's vaccination? その病気の主治医には、今日の予防接種を受けてよいといわれましたか。	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
10. Have you ever had spasms or convulsions? If yes, when? At age (). ひきつけ(けいれん)をおこしたことがありますか。 ()歳頃	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Were the spasms or convulsions accompanied by a fever? そのとき熱がでましたか。	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
11. Have you ever been diagnosed with respiratory disease such as interstitial pneumonitis and bronchial asthma? 間質性肺炎、気管支喘息などの呼吸器疾患にかかったことがありますか。	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
12. Have you ever had a rash, hives, or other adverse reaction to food (chicken meat or eggs) or medicine? 薬や食品で皮膚に発疹やじんましんが出たり、体の具合が悪くなったことがありますか。	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
13. Do you have any close relatives who became ill after a vaccination? 近親者に予防接種を受けて具合が悪くなった方はいますか。	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
14. Do you have any close relatives who were diagnosed with a congenital immunodeficiency? 近親者に先天性免疫不全と診断されている方はいますか。	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
15. (Women only) Are you currently pregnant or is there a possibility you may be pregnant? (女性のみ) 現在妊娠している、又は妊娠している可能性はありますか。	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
16. Do you have any questions about today's vaccination? 今日の予防接種について質問がありますか。	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

To be completed by physician (医師の記入欄)

Based on the questions above, today's vaccination should (proceed / be postponed).

以上の問診及び診察の結果、今日の予防接種は(可能 ・ 見合わせる)

I have explained the effects and side-effects of vaccination, as well as the relief system for sufferers from adverse drug reactions to the recipient.

保護者に対し、予防接種の効果や副反応及び予防接種健康被害救済制度について、説明をした。

Physician's signature 医師署名又は記名押印 _____

To be completed by recipient (受ける人の記入欄)

I have consulted with the physician, I understand the explanations, and I am aware of the vaccination's purpose, effects, benefits, and of the possibility of serious side-effects. I have decided that:

医師の診察・説明を受け、予防接種の効果・目的、接種するワクチンの有益性、重篤な副反応の可能性などについて理解した上で、以下のワクチン接種を

I want to proceed with vaccination 接種を希望します ・ I do not want to proceed with vaccination 接種を希望しません

Signature 白署

ワクチンメーカー名、ロット番号	接種量	実施場所. 医師名. 接種年月日
メーカー名 Lot No.	ml	実施場所 医師名 接種年月日 平成 年 月 日

Cautions following Vaccinations

予防接種後の注意

- ① For 30 minutes after inoculations, you should observe your condition at the medical institution, or make sure to be able to get in touch with the doctor. There might be sudden side reactions during this time.
- ② After inoculations, be aware of side reactions. Watch for 24 hours.
- ③ Inoculation sites should be kept clean. Bathing on the inoculation day is fine, but you should not rub the inoculation site.
- ④ Avoid any heavy physical exercises on the inoculation day.
- ⑤ After the inoculation, consult the doctor immediately if any extreme side reactions happen.