

Influenza Vaccination (Flu Shot) – Medical History

インフルエンザ予防接種 予診票（英語版）

Please fill out the form in ballpoint pen within the bolded brackets.

Please circle either in the answer column.

※太ワク内にボールペンにてご記入下さい。回答欄にはどちらかに○印をつけてください。

		Body temperature before exam 診察前の体温		℃
Office name 事業所名			TEL	() –
belong to 所属				
furigana フリガナ			Date of Birth 生年月日	year年 month月 day日 (years old歳 monthsヵ月)
Name of patient 受ける人の氏名	☐ Male男 ☐ Female 女			
Questions 質 問 事 項			Answers 回 答 欄	Doctor's Notes 医師記入欄
1. Did you read and understand the explanation about the vaccination you are about to receive today? 今日受けるインフルエンザの予防接種について説明文（裏面）を読んで理解しましたか			No	Yes
2. Are you feeling sick today at all? 今日、体に具合の悪いところがありますか			Yes	No
3. Are you currently going to the doctor for any sort of illness? 現在、何かの病気で医師にかかっていますか name of a disease病名 ()			Yes	No
Are you receiving treatment (medication, etc)? その場合、治療（投薬など）を受けていますか			Yes	No
Did the doctor treating you say it was alright to get the influenza vaccination? その病気の主治医には、今日の予防接種を受けてもよいと言われましたか			No	Yes
4. Have you been sick in the last month? 最近1ヵ月以内に熱が出たり、病気にかかったりしましたか name of a disease病名 ()			Yes	No
5. Have you ever been diagnosed with a serious illness? 今までに特別な病気にかかり医師の診察を受けていますか ☐ cardiovascular 心臓血管系 ☐ kidneys腎臓 ☐ liver 肝臓 ☐ blood disease血液疾患 ☐ immunodeficiency disease 免疫不全症 ☐ other その他 ()			Yes	No
6. Have you ever had a rash, hives, or other reaction to certain medicines or foods? 薬や食品で皮膚に発しんやじんましんがでたり、体の具合が悪くなったことがありますか ☐ eggs 卵 ☐ chicken 鶏肉 ☐ other その他 ()			Yes	No
7. Have you ever received a flu shot? インフルエンザの予防接種を受けたことがありますか ①Date last received前回受けたのは (year年 month月頃)			No	Yes
②Have you ever felt sick when doing so?その際に具合が悪くなったことはありますか			Yes	No
③Have you ever been sick during any immunization other than influenza? インフルエンザ以外の予防接種の際に具合が悪くなったことがありますか Immunization Name予防接種名 ()			Yes	No
8. Have you received any immunization other than influenza within 4 weeks? 4週間以内にインフルエンザ以外の予防接種を受けましたか Immunization Name予防接種名 () day of inoculation接種日 (month月 day日)			Yes	No
9. Have you ever had a seizure (convulsion)? 今までにけいれん（ひきつけ）を起こしたことがありますか			Yes	No
10. Have you ever been diagnosed with respiratory diseases such as interstitial pneumonia or bronchial asthma? 今までに間質性肺炎、気管支喘息などの呼吸器系疾患と診断されたことがありますか			Yes	No
11. Do you have a close relative with congenital immunodeficiency? 近親者に先天性免疫不全症の方がいますか			Yes	No
12. Has anyone in your immediate family gotten sick after receiving vaccinations? 近親者の中に予防接種を受けて、具合が悪くなった方はいますか			Yes	No
13. Have any of your family members or friends had measles, rubella, chickenpox, or mumps in the past month? 最近1ヵ月以内に家族や友達に麻疹、風疹、水痘、おたふくかぜなどの病気の方がいましたか name of a disease病名 ()			Yes	No
14. (Women only) Are you currently pregnant? (女性の方に) 現在妊娠していますか			Yes	No
15. If there are any other things about your health that you want to tell the doctor, please write them here. その他、健康状態のことで医師に伝えておきたいこと質問があれば具体的に記入ください ()				

Doctor's Notes 医師記入欄

以上の問診及び診察の結果、今日の予防接種は（実施できる ・ 見合わせた方がよい）と判断します
本人に対して予防接種の効果・副反応及び医薬品医療機器総合機構法に基づく救済について説明しました

医師署名又は記名捺印

To be filled in by the person himself 本人記入

I agree to be vaccinated after receiving a diagnosis and explanation from a doctor and understanding the effects and purpose of the vaccination and the possibility of adverse reactions (I agree ・ I do not agree) *Circle one of the boxes below.

signature署名

(For substitute writers: Continuation

（なお、被接種者が自筆できない場合は代筆者が署名し、被接種者との関係を記載してください。）

使用ワクチン名	用法・用量	接種場所・医師名・接種日
名 称：	皮下接種	医療機関名： みなとみらい小児科クリニック
メーカー名：	0.5 mL	医 師 名： 渡辺 真
製造番号：	回目	接 種 日： 年 月 日

記載いただきました個人情報はワクチン接種の予診にに関してのみ使用します。

The Influenza Vaccination

In order to administer the influenza vaccination (or flu shot) to a patient, we must first know the patient's health condition, so please fill out the medical history sheet as thoroughly as possible. A guardian with adequate knowledge of their child's health condition may fill out the form for their child.

Effects and Side Effects of the Vaccination

With the vaccination, it is possible to prevent influenza and the complications and deaths associated with the influenza virus.

Generally, side effects are mild. The injection site may redden, become swollen, become hard, feel hot, hurt, or feel numb, but these symptoms normally disappear within 2-3 days. You may also experience fever, chills, headaches, lethargy, temporary loss of consciousness, dizziness, swollen lymph nodes, vomiting or nausea, stomachaches, diarrhea, loss of appetite, joint pain, and/or muscular pain, but these symptoms normally disappear within 2-3 days. An oversensitivity to the vaccination may lead to rashes, hives, eczema, erythema, erythema multiforme, and/or itchiness, as well as facial palsy and other forms of paralysis, peripheral neuropathy, and/or uveitis. Please tell your doctor if you have a strong allergy to eggs, as there is the possibility of serious side effects. The following side effects are extremely rare but have been known to occur: 1) shock, anaphylactic reaction (hives, difficulty breathing, etc), 2) acute disseminated encephalomyelitis (fever, headaches, seizures, impaired mobility, impaired consciousness, etc, within 2 weeks after receiving the vaccination), 3) Guillain-Barre syndrome (numbness in both hands or feet, difficulty walking, etc), 4) seizures (including fever convulsions), 5) liver function impairment, jaundice, 6) emergence of asthma symptoms, 7) thrombocytopenic purpura, decrease in platelets, 8) vasculitis (allergic purpura, allergic granulomatous angiitis, leukocytoclastic vasculitis, etc). Please tell your doctor if you have any symptoms corresponding to the above side effects. If you have suffered an injury to your health (any sickness or injury that requires hospitalization), you or your family can receive relief services in accords with the Law for the Pharmaceuticals and Medical Devices Agency.

Patients that cannot receive the influenza vaccination:

- 1 Patients found with a high fever (above 37.5°C)
- 2 Patients found to be suffering from a serious acute illness
- 3 Patients who have had an anaphylactic reaction to the influenza vaccination in the past
Additionally, patients who have had an anaphylactic reaction to any administered or prescribed medicine in the past must tell their doctors before receiving the influenza vaccination.
- 4 Any other person determined by their doctor to be unable to receive the vaccination

Patients that must consult with their doctor before receiving the influenza vaccination:

- 1 Patients with heart disease, kidney disease, liver disease, blood disease, or other serious illness
- 2 Patients with delayed development and receiving care from their doctor and health nurses
- 3 Patients recovering from a cold or other illness
- 4 Patients that had a fever within two days of a vaccination, or allergic complications like rashes or hives
- 5 Patients who have experienced rashes on the skin from medicine or food (containing chicken eggs or chicken meat), or otherwise felt unwell
- 6 Patients who have experienced seizures (convulsions) in the past
- 7 Patients who have been diagnosed with or have had relatives diagnosed with immunodeficiencies in the past
- 8 Pregnant women
- 9 Patients with interstitial pneumonia, bronchial asthma, or other types of respiratory illnesses

Caution - Please Read

- 1 You may experience sudden side effects in the 30 minutes after receiving the influenza vaccination. Stay within the medical facility so that you can observe your symptoms and promptly contact a doctor if necessary.
- 2 Keep the injection site clean and hygienic. You may use the shower or bath the same day you have been vaccinated but do not rub, scratch, or scrub the injection site.
- 3 Continue your daily routine on the day of the vaccination. Avoid extreme exercise or over-consumption of alcohol.
- 4 In the small chance that you experience a high fever, seizures, or other serious side effects, please consult a doctor as soon as possible.