Influenza Vaccination (Flu Shot) – Medical History

インフルエンザ予防接種予診票（英語）

***Please write within the boxes. 接種希望の方へ：太ワク内**にご記入ください。

*Guardians with adequate knowledge of their child's health condition may fill out the form for their child.
お子さんの場合には、健康状態をよく把握している保護者がご記入ください。

Body temperature before exam 診察前の体温	℃

Address 住所		TEL	
Name of patient 受ける人の名前		Sex 性別	☐Male 男　☐ Female 女
(Guardian's name) （保護者の氏名）		Date of Birth 生年月日	year 年　month 月　day 日 （　years old 歳　(months)ヶ月）

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? 今日受ける予防接種についての説明文を読んで理解しましたか	☐ No いいえ	☐ Yes はい	
2 Is today your first influenza vaccination (flu shot) of this season? 今日受けるインフルエンザ予防接種は今シーズン1回目ですか	☐ No いいえ This is my ____ time 回目	☐ Yes はい	
3 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 ある	☐ No ない	
4 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	☐ Yes はい	☐ No いいえ	
・Are you receiving treatment (medication, etc)? 治療（投薬など）を受けていますか	☐ Yes はい	☐ No いいえ	
・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 いいえ	☐ Yes はい	
5 Have you been sick in the last month? 最近1ヶ月以内に病気にかかりましたか	☐ Yes はい	☐ No いいえ	
6 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	☐ Yes はい	☐ No いいえ	
7 Have you ever been diagnosed with interstitial pneumonia, bronchial asthma, or other types of respiratory illnesses? If so, are you currently in treatment? 間質性肺炎や気管支喘息等の呼吸器系疾患と診断され、現在、治療中ですか	☐ Yes はい ____ year 年 ____ month 月頃 ☐Currently in treatment 現在治療中 ☐Not in treatment 治療していない	☐ No いいえ	
8 Have you ever had a seizure (convulsions) ? 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 ある ____ times 回ぐらい The last one was 最後は ____ year 年 ____ month 月頃	☐ No ない	
9 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	☐ Yes ある Medicine or food name:	☐ No ない	
10 Have you or any of your relatives been diagnosed with a congenital immunodeficiency? 近親者に先天性免疫不全と診断された方がいますか	☐ Yes はい	☐ No いいえ	
11 Have you, your family, or anyone around you contracted measles, rubella, chicken pox, or mumps in the last month? 1ヶ月以内に家族や周囲で麻しん、風しん、水痘、おたふくかぜなどにかかった方がいますか。	☐ Yes いる	☐ No いない	
12 Have you received any vaccinations in the last month? 1ヶ月以内に予防接種を受けましたか	☐ Yes はい Name of vaccination	☐ No いいえ	
13 Have you ever felt sick after receiving a vaccination? 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	☐ Yes ある Name of vaccination	☐ No ない	
14 (Women only) Are you currently pregnant? （女性の方に）現在妊娠していますか	☐ Yes はい	☐ No いいえ	
15 (If the vaccination is for a child) （予防接種を受けられる方がお子さんの場合） Were there any problems with the child's health during labor, delivery, or infancy? 分娩時、出生時、乳幼児健診などで異常がありましたか	☐ Yes ある ☐labor 分娩時_____ ☐delivery 出生時_____ ☐infancy 乳幼児健診_____	☐ No ない	
16 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があれば、具体的に書いてください。			

医師の記入欄：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）本人（もしくは保護者）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、説明した。**医師の署名又は記名押印**

After an examination with the doctor, I have heard and understood the doctor's explanation about the vaccination, its effects and purpose, and the possibility of serious side effects. 医師の診察・説明を受け、予防接種の効果や目的、重篤な副反応の可能性などについて理解した上で、接種を希望しますか。 ☐Yes, I want to receive the vaccination 接種を希望します ☐No, I do not want to receive the vaccination 接種を希望しません	Patient's Signature (Guardian's Signature) 本人の署名（または保護者の署名） *Patients that are not able to write themselves must have a representative sign and state their relationship to the patient. 自書できない者は代筆者が署名し、代筆者氏名及び被接種者との続柄を記載。

使用ワクチン名	用法・用量	実施場所・医師名・接種日時
インフルエンザ HA ワクチン Lot. No	☐0.5ml（3歳以上） ☐0.25ml（6ヶ月以上3歳未満）	みなとみらい小児科クリニック 渡　辺　　眞

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℃)
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.