

# 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をご記入ください。

Body temperature before exam 診察前の体温	℃
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Address 住所	TEL
Name of patient 受ける人の名前	Sex 性別 <input type="checkbox"/> Male 男 <input type="checkbox"/> 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	<input type="checkbox"/> No いいえ <input type="checkbox"/> 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	<input type="checkbox"/> No いいえ This is my _____ time 回目 My last shot was 前回の接種は _____ month 月 _____ day 日.	<input type="checkbox"/> 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	<input type="checkbox"/> Yes ある <input type="checkbox"/> 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	<input type="checkbox"/> Yes はい <input type="checkbox"/> No いいえ	
•Are you receiving treatment (medication, etc)? 治療(投薬など)を受けていますか	<input type="checkbox"/> Yes はい <input type="checkbox"/> 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。	<input type="checkbox"/> No いいえ <input type="checkbox"/> 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	<input type="checkbox"/> Yes はい <input type="checkbox"/> 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	<input type="checkbox"/> Yes はい <input type="checkbox"/> cardiovascular 心臓血管系 <input type="checkbox"/> kidneys 腎臓 <input type="checkbox"/> liver 肝臓 <input type="checkbox"/> blood disease 血液疾患 <input type="checkbox"/> immunodeficiency disease 免疫不全症	<input type="checkbox"/> 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	<input type="checkbox"/> Yes はい _____ year 年 _____ month 月頃 <input type="checkbox"/> Currently in treatment 現在治療中 <input type="checkbox"/> Not in treatment 治療していない	<input type="checkbox"/> 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	<input type="checkbox"/> Yes ある _____ times 回ぐらい The last one was 最後は _____ year 年 _____ month 月頃	<input type="checkbox"/> 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	<input type="checkbox"/> Yes ある Medicine or food name: 薬または食品の名前 <input type="checkbox"/> eggs 卵 <input type="checkbox"/> chicken 鶏肉 <input type="checkbox"/> other その他	<input type="checkbox"/> 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	<input type="checkbox"/> Yes はい <input type="checkbox"/> 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疹、風しん、水痘、おたふくかぜなどにかかった方がいますか。	<input type="checkbox"/> Yes いる <input type="checkbox"/> measles 麻疹 <input type="checkbox"/> rubella 風しん <input type="checkbox"/> chicken pox 水痘 <input type="checkbox"/> mumps おたふくかぜ	<input type="checkbox"/> 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	<input type="checkbox"/> Yes はい Name of vaccination 予防接種名	<input type="checkbox"/> 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	<input type="checkbox"/> Yes ある Name of vaccination 予防接種名 <input type="checkbox"/> Influenza vaccination インフルエンザ予防接種 <input type="checkbox"/> Other その他	<input type="checkbox"/> 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	<input type="checkbox"/> Yes はい <input type="checkbox"/> 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	<input type="checkbox"/> Yes ある <input type="checkbox"/> labor 分娩時 _____ <input type="checkbox"/> delivery 出生時 _____ <input type="checkbox"/> infancy 乳幼児健診 _____	<input type="checkbox"/> 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) 医師の署名又は記名押印 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。	
<p>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.</p> <p>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。</p> <p><input type="checkbox"/> Yes, I want to receive the vaccination 接種を希望します</p> <p><input type="checkbox"/> No, I do not want to receive the vaccination 接種を希望しません</p>	<p>Patient's Signature (Guardian's Signature)</p> <p>本人の署名(または保護者の署名)</p> <p>*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。</p>

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.	皮下接種 <input type="checkbox"/> 0.5ml (3歳以上) <input type="checkbox"/> 0.25ml (6ヶ月以上3歳未満)	実施場所： 医師名： 接種日時： 年 月 日 :時 分
<input type="checkbox"/> 化血研 <input type="checkbox"/> デンカ生研			
カルテ No.			

## **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.