**COLCHESTER MEDICAL PRACTICE**

**FLU VACCINATION PROGRAMME**

Today’s appointment is for flu vaccination **only.** There will be no time to discuss any other matters

**PLEASE COMPLETE THE FOLLOWING, AND HAND IT TO THE DOCTOR OR NURSE WHEN YOU HAVE YOUR FLU VACCINATION.**

**Patient Name**…………………………………………………………………………………………….

**Date of Birth**…………………………

**Height**………………. **Weight** (approx.)…………………..

**Smoking Status**

Do you smoke Yes / NoIf Yes, how many. …………..

Ex-SmokerYes / No When stopped…………………..

Do you have a serious allergy to either hens eggs or antibiotics? **YES/NO**

Have you have a previous allergic reaction to the flu vaccine? **YES/NO**

Are you unwell with anything that involves a raised temperature? **YES/NO**

Are you currently taking any steroid medication? **YES/NO**

Are you currently undergoing chemotherapy? **YES/NO**

Are you currently on Warfarin? **YES/NO**

**Thank you**