

Influenza Vaccination (Flu Shot) – Medical History

インフルエンザ予防接種 予診票

Please write within the boxes. 接種希望の方へ：太枠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	°C
Address 住所	〒		
		TEL ()	-
フリガナ		Sex 性別	☐ Male 男 ☐ Female 女
Name of patient 受ける人の氏名		Date of Birth 生年月日	year 年 month 月 day 日
Guardian's name 保護者の氏名		(years old 歳 months ヶ月)	
1. Staff 職員	For Kyushu University students, please answer the following questions. 九州大学の学生の方のみ、ご回答ください。		
2. Student 学生	Q1. About the academic curriculum. Circle the number that applies. 課程について。該当する番号に○をつけてください。 1. undergraduate 学部生 2. Master 院生／修士 3. Doctor 院生／博士 4. Other その他 ()		
3. General 一般	Q2. What year are you in? Circle the number that applies. 何年次ですか。該当する番号に○をつけてください。 1. first 2. second 3. third 4. fourth 5. fifth 6. sixth 1 年次 2 年次 3 年次 4 年次 5 年次 6 年次		

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書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 ☐ Yes はい This is my _____ time 回目 My last shot was 前回の接種は _____ month 月 _____ day 日	
3 (If the vaccination is for a child) (予防接種を受けられる方がお子さまの場合) 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 ☐ No ない ☐ labor 分娩時 _____ ☐ delivery 出産時 _____ ☐ infancy 乳幼児健診 _____	
4 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	
5 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 Name of the illness 病名 ()	
• 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 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。	☐ Yes はい ☐ No いいえ	
6 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 Name of the illness 病名 ()	
7 Have you, your family, or anyone around you contracted measles, rubella, chicken pox, or mumps in the last month? 最近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った方はいますか。	☐ Yes いる ☐ No いない ☐ measles 麻疹 ☐ rubella 風しん ☐ chicken pox 水痘 ☐ mumps おたふくかぜ	
8 Have you received any vaccinations in the last month? 最近1ヶ月以内に予防接種を受けましたか。	☐ Yes はい ☐ No いいえ Name of vaccination 予防接種名 _____	
9 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 ☐ No ない Name of vaccination ☐ Influenza vaccination インフルエンザ 予防接種 ☐ other その他 _____	

10 Have you ever been diagnosed with a serious illness? これまでに特別な病気にかかり医師の診断を受けましたか。	☐ Yes はい ☐ Congenital abnormality 先天性異常 ☐ cardiovascular 心臓血管系 ☐ kidneys 腎臓 ☐ liver 肝臓 ☐ blood disease 血液疾患 ☐ Brain nerve 脳神経 ☐ immunodeficiency disease 免疫不全症 ☐ Cancer 悪性腫瘍 ☐ other その他_____	☐ No いいえ	
(If 'Yes') Did the doctor treating your illness say it's okay for you to get today's shot? （“ある”の場合）その病気を診てもらっている医師に、今日の予防接種を受けて良いといわれましたか	☐ Yes はい	☐ No いいえ	
11 Have you ever had a seizure (convulsions)? これまでにけいれん（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	
Have you ever been diagnosed with interstitial pneumonia, bronchial asthma, or other types of respiratory illnesses? If so, are you currently in treatment? これまでに間質性肺炎や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 はい _____ year 年 _____ month 月 ☐ Currently in treatment 現在治療中 ☐ Not in treatment 治療していない	☐ No いいえ	
13 Have you ever had a rash, hives, or other reaction to certain medicines or foods? これまでに薬や食品で皮膚に発疹が出たり、体の具合が悪くなったことはありますか。	☐ Yes ある Medicine or food name (_____) 薬または食品の名前 ☐ eggs 卵 ☐ chicken 鶏肉 ☐ other その他 (_____)	☐ No ない	
14 Have any of your close relatives become unwell after receiving a vaccination? 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 ある Name of vaccination 予防接種名 _____	☐ No いない	
15 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	
16 (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	
17 If there are any other things about your health that you want to tell the doctor, please write them here.(Current medication status, etc.) 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。（投薬状況など）			

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。また、本剤の接種対象年齢を確認した。	医師の署名又は記名押印 _____
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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、予防接種の効果や副反応の可能性などについて理解した上で、接種することを希望しますか。 ☐ 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. （被接種者が自署できない場合、代筆者が署名し、被接種者との続柄を記載ください。） 続柄 _____
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ワクチンロット番号	接種量	実施場所・医師名・接種日時
Lot No.	皮下接種 0.5 mL	医療機関名： 九州大学伊都診療所 医 師 名： 西原 智恵 接種年月日： _____ 年 _____ 月 _____ 日

The personal information you have provided will be used exclusively for the preliminary consultation regarding vaccination.
記載いただきました個人情報 Wakuchin 接種の予診に関してのみ使用いたします。

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.

Effects and Side Effects of the Vaccination

With the vaccination, it is expected to prevent the onset of the influenza and reduce its symptoms.

The following are listed as side effects. 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) encephalitis/encephalopathy, myelitis, optic neuritis, 4) Guillain-Barre syndrome (numbness in both hands or feet, difficulty walking, etc), 5) seizures (including fever convulsions), 6) liver function impairment, jaundice, 7) emergence of asthma symptoms, 8) Immune thrombocytopenia, decrease in platelets, 9) vasculitis (IgA vasculitis, granulomatosis with eosinophilic polyangiitis, leukocytoclastic vasculitis, etc), 10) interstitial pneumonia, 11) mucocutaneous ocular syndrome (Stevens-Johnson syndrome), acute generalized exanthematous pustulosis, 12) nephrotic syndrome.

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

Caution after vaccination

- 1 You may experience acute side effects after receiving the influenza vaccination. Observe your symptoms for 30 minutes 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 If you experience a high fever, seizures, or other serious side effects, please consult a doctor as soon as possible.