Post-Service Flu Vaccine Information Form

Post-Service Flu Vaccine Information Form

Client Name:_____

Client Address:_____

City:_____ State:_____ Zip:_____

Client phone #:_____ Date of service received: ____/____/____

Please tell us about the flu vaccine service your received. Use scale 1-5 (1=dissatisfied, 2=somewhat dissatisfied, 3=good, 4=very satisfied, 5=excellent). Circle one please.

1. Dissatisfied 2. Somewhat dissatisfied 3. Good 4. Very satisfied 5. Excellent

Please tell us if you had side effects (i.e. fever, malaise, myalgia, and other symptoms) of the flu vaccine for more than:

1. One week 2. Two weeks 3. More than two weeks.

What action(s) did you take to deal with the symptoms? Please choose one answer.

1. Did you call PHS nursing office?
2. Did you see your doctor?
3. Did you go to the hospital?
4. You did nothing. You let the symptoms take their course.

Tell us how we may better serve you next time? Use the extra space below for your comments and suggestions.

_____

_____

_____

_____

_____

Please mail or fax your form to:

Pleasant Health Services, Inc.,
20 Long Green Ct,
Silver Spring, MD 20906.
Tel: 301-460-6372, Fax: 301-871-4515.