**FOR CHILD < 6 MONTHS:**

1) Did [you (if speaking to patient’s mother)/patient’s mother] receive the influenza vaccine during fall or winter of the current influenza season?

 🞎 Yes (go to Q1a)

 🞎 No (go to Q2)

 🞎 Unknown (go to Q2)

1a) If yes, what vaccine type did [you/the patient’s mother] receive?

 🞎 Shot [Injected vaccine --Trivalent inactivated influenza vaccine (TIV)]

 🞎 Spray [Nasal spray -- Live-attenuated influenza vaccine (LAIV)]

 🞎 Unknown

*[If injected vaccine/trivalent inactivated influenza vaccine (TIV), go to 1b; if not then skip to 2]*

1b) What type of injected vaccine did [you/patient’s mother] receive?

 🞎 Regular IM

 🞎 High dose IM

 🞎 Intradermal

 🞎 TIV type unknown

2) At any time, did [your child/patient’s name] receive the pneumonia vaccine [may need to read: pneumococcal, PCV(7), PCV(13), or Prevnar®]?

 🞎 Yes

 🞎 No

 🞎 Unknown

*[If YES, continue to Q2a; if NO/UNKNOWN then proceed to race/ethnicity (Q3), if needed]*

2a) Can you tell me the dates [your child's/patient’s name] received the pneumonia vaccine?

 1) \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ [MM-DD-YYYY]

 2) \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ [MM-DD-YYYY]

 3) \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ [MM-DD-YYYY]

 4) \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ [MM-DD-YYYY]

3) Can you tell me what [your child’s/patient’s name] ethnicity is?

🞎 Hispanic or Latino

🞎 Non-Hispanic or Latino

🞎 Not Specified (refused to answer)

Are you / they….? (check all that apply)

🞎 American Indian or Alaska Native White

🞎 Asian

🞎 Black or African American

🞎 Native Hawaiian or other Pacific Islander

🞎 White

🞎 Not specified (refused)

**FOR CHILD 6 MONTHS OR OLDER:**

1. Since September [flu season year], did [you / child’s name] receive a flu shot or flu vaccine ? This vaccine is offered every year to protect against the flu.

 🞎 Yes (go to Q1a)

 🞎 No (go to Q2)

 🞎 Unknown (go to Q2)

1a) For each dose received, can you tell me the date [you/child’s name] received flu vaccine?

 1) \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ [MM-DD-YYYY]

 2) \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ [MM-DD-YYYY]

1b) Did [you/child’s name] receive a shot or was it sprayed into their nose?

 🞎 Shot [Injected vaccine --Trivalent inactivated influenza vaccine (TIV)]

 🞎 Spray [Nasal spray -- Live-attenuated influenza vaccine (LAIV)]

 🞎 Unknown

*[If patient is less than 9 years of age proceed to Q2; if patient is 9 years of age or older, proceed to Q3]*

2). Did [you/child’s name] receive influenza vaccine in any previous years?

 🞎 Yes

 🞎 No

 🞎 Unknown

3). At any time, did [you/child’s name] receive the pneumonia vaccine [may need to read: pneumococcal, PCV(7), PCV(13), or Prevnar®]?

 🞎 Yes

 🞎 No

 🞎 Unknown

*[If YES, continue to Q3a; if NO/UNKNOWN, proceed to race/ethnicity (Q4) and height/weight questions (Q5), if needed]*

3a) Can you tell me the dates [you/child’s name] received the pneumonia vaccine?

 1) \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ [MM-DD-YYYY]

 2) \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ [MM-DD-YYYY]

 3) \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ [MM-DD-YYYY]

 4) \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ [MM-DD-YYYY]

*[If medical record is incomplete then ask race/ethnicity(Q4); otherwise skip to Q5.]*

4) Can you tell me what [your/child’s name] ethnicity is?

🞎 Hispanic or Latino

🞎 Non-Hispanic or Latino

🞎 Not Specified (refused to answer)

Are you / they….? (check all that apply)

🞎 American Indian or Alaska Native White

🞎 Asian

🞎 Black or African American

🞎 Native Hawaiian or other Pacific Islander

🞎 White

🞎 Not specified (refused)

*[If medical record is incomplete to calculate BMI, then ask height and weight; Do not ask BMI questions if patient is pregnant or less than 2 years of age]*

5. Can you tell me [your/child’s name] height and weight?

 HEIGHT: \_\_\_\_\_ 🞎 Inches

 🞎 Centimeters

 🞎 Unknown height

 WEIGHT: \_\_\_\_\_ 🞎 Pounds

 🞎 Kilograms

 🞎 Unknown weight

**FOR ADULTS:**

1. Since September [flu season year], did [you/patient’s name] receive a flu shot or flu vaccine? This vaccine is offered every year to protect against the flu.

 🞎 Yes (go to Q1a)

 🞎 No (go to Q2)

 🞎 Unknown (go to Q2)

1a) Can you tell me the date [you/patient’s name] received flu vaccine?

 1) \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ [MM-DD-YYYY

1b) Did [you/patient’s name] receive a shot or was it sprayed into your nose?

 🞎 Shot [Injected vaccine --Trivalent inactivated influenza vaccine (TIV)]

 🞎 Spray [Nasal spray -- Live-attenuated influenza vaccine (LAIV)]

 🞎 Unknown

*[If injected vaccine/trivalent inactivated influenza vaccine (TIV), go to 1c; if not then skip to 2]*

1c) What type of injected vaccine did [you/patient’s name] receive?

 🞎 Regular IM

 🞎 High dose IM

 🞎 Intradermal

 🞎 TIV type unknown

1c) Can you tell me the date [you/patient’s name] received flu vaccine?

 1) \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ [MM-DD-YYYY]

2) At any time, did [you/patient’s name) receive the pneumonia vaccine [may need to read: pneumococcal, Pneumovax®]?

 🞎 Yes

 🞎 No

 🞎 Unknown

*[If YES, continue to Q2a for patient’s less than 65 years and Q2b for patients 65 years and older; if NO/UNKNOWN proceed to race/ethnicity (Q3) and height/weight questions (Q4), if needed]*

2a) Can you tell me the dates [you/patient’s name] received the pneumonia vaccine?

 1) \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ [MM-DD-YYYY]

 2) \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ [MM-DD-YYYY]

 3) \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ [MM-DD-YYYY]

 4) \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ [MM-DD-YYYY]

2b) Did [you/patient’s name] receive the pneumonia vaccine within the last five years?

 🞎 Yes

 🞎 No

 🞎 Unknown

*[If medical record is incomplete then ask race/ethnicity (Q3); otherwise skip to Q4]*

3) Can you tell me what [your/patient’s name] ethnicity is?

🞎 Hispanic or Latino

🞎 Non-Hispanic or Latino

🞎 Not Specified (refused to answer)

Are you / they….? (check all that apply)

🞎 American Indian or Alaska Native White

🞎 Asian

🞎 Black or African American

🞎 Native Hawaiian or other Pacific Islander

🞎 White

🞎 Not specified (refused)

*[If medical record is incomplete to calculate BMI, then ask height and weight; Do not ask BMI questions if patient is pregnant ]*

4) Can you tell me [your/patient’s name] and weight?

 HEIGHT: \_\_\_\_\_ 🞎 Inches

 🞎 Centimeters

 🞎 Unknown height

 WEIGHT: \_\_\_\_\_ 🞎 Pounds

 🞎 Kilograms

 🞎 Unknown weight

**THE END. These are all my questions. Do you have any questions for me? [If yes, answer.] Thank you for your time.**