Patient Name: _____ Patient Chart#_____

Email address: _____

Primary Care Physician: _____ Phone _____ Fax _____

Referring Physician: _____ Phone _____ Fax _____

Self referred? Yes No

Immunizations: (please circle correct answer)

Have you received the Meningococcal Immunization? **(Adolescent Patients age 11-13)** **Yes No**

If not, why? Allergy to vaccine Refused

Have you received the Td/Tdap Immunization? **(Adolescent Patients age 12-13)** **Yes No**

If not, why? Allergy to vaccine/other medical reasons Refused

Have you received the HPV vaccine? **(Adolescent Patients age 9-13)** **Yes No**

If not, why? Allergy to vaccine/other medical reasons Refused

Social History: (please circle all that apply)

Cigarette Smoking/Tobacco Use:

Never Smoker Heavy tobacco smoker

Former Smoker Light tobacco smoker

Current every day smoker Cigar smoker

Current some day smoker(tobacco) Vaping

Current some day smoker(cigarettes) Chewing tobacco

Alcohol Use: (For patients 18 and over)

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? (0-366 days) _____

For patients 65 or older:

Do you have an Advanced Care Plan, or surrogate decision maker in place to make medical decisions on your behalf if you are/were unable to? Yes No

If yes, please provide us with the name and phone number of that person:

Patient/Guardian Signature:_____ Date:_____