

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 a flu vaccine during this flu season? Yes No

If not, why? Allergy to vaccine Refused

Have you received a Pneumonia vaccine? (For patients 65 or older) Yes No

**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: \_\_\_\_\_