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:_______________________