Patient Name: _____ Date: _____

Were you referred by a Physician?

Referring Physician name: _____

Tobacco use? (circle answer below)	**Have you had the Flu shot? (circle answer below)**
Never used	Yes; date of last:
Former User	No, for personal reasons
Current user	No, I'm allergic

For Patients 65 years or older:

Have you had a pneumonia vaccine?	**Do you have an advanced directive?**	**Yes**	**No**
Yes; approximate date given:	**Do you have a medical power of Attorney?**	**Yes**	**No**
No, for personal reasons	**If yes, is it currently in effect?**	**Yes**	**No**
No, I'm allergic	**If yes, who? (document name below)**		
	Name:		