DMG

Patient Name: _____ Date: _____

Were you referred by a Physician? If yes, by who? _____

Primary Care Physician: _____

Tobacco use? (circle answer below)
Never used
Former user
Current user

For Patients 65 years or older:

Do you have an advanced directive?	Yes	No
Do you have a medical power of attorney?	Yes	No
If yes, is it currently in effect?	Yes	No
If yes, please list name of acting medical power of attorney:		