



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:		