Patient Name:_____ Date of Visit: _____

Date of Birth_____Pharmacy _____

Email (for return visit notifications) _____

Occupation _____
If retired, occupation before you retired _____

Primary Care Provider (Family Doctor) _____
Referring Doctor (if applicable)_____

1) Do you have an Advanced Care Plan/Advanced Medical Directive?
Yes_____ No_____ If yes, please bring a copy to place in your chart

Please list who we should contact in case of an emergency. List your decision maker of who will be making medical decisions on your behalf if you are unable to do so

Name:_____
Relationship_____
Phone Number_____

2) Have you received the Influenza (flu) vaccine in 2023 or 2024? Yes _____ No _____
If yes, date if known:_____

3) Have you ever received the Pneumococcal (pneumonia) vaccine? Yes _____ No _____
If yes, date if known:_____

4) Have you received the Tdap (Tetanus, Diphtheria, Pertussis) vaccine? Yes ____ No ___
If yes, date if known: _____

5) Have you received the Zoster (Shingles) vaccine? Yes _____ No _____
If yes, date if known: _____

6) Have you received the meningococcal (Meningitis) vaccine for adolescents? Yes_____
No_____ If yes, date if known: _____

7) Have you received the HPV vaccine for adolescents? Yes_____ No_____
If yes, date if known:_____

8) Have you received the COVID-19 vaccine? Yes _____ No _____
Have you tested positive for COVID-19 within the last year? Yes _____ No _____

9) Do you currently smoke, vape or use any tobacco product?
Yes _____ No _____