

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 2022 or 2023? 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 _____