PATIENT INTAKE FORM

Please answer the following questions so we can comply with our practice policies. Thank you.

Do you have any of the following?

Yes☐ No☐ Heart failure?
Yes☐ No☐ Coronary Artery Disease (CAD)?
Yes☐ No☐ Chronic Obstructive Pulmonary Disorder (COPD)?
Yes☐ No☐ Diabetes?

Did you receive the flu vaccine this past season? Yes☐ No☐
If NO, please explain why

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Have you ever received the pneumonia vaccine? Yes☐ No☐

Do you have history of melanoma? Yes☐ No☐

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women?

☐Never
☐Once
☐Two or more
☐Daily
☐Weekly

Do you have a Primary Care Physician? Yes☐ No☐
If YES, who is your PCP ____
Month and year of last visit with PCP ________________________________

Do you have an Advanced Care Plan? Yes☐ No☐
If YES, who is your surrogate decision maker or healthcare proxy?

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Name _________________________________ DOB __________ Date __________