PATIENT INTAKE FORM

Patient Name: ____________________________

Date of Birth: _____________________________

Phone Number: ___________________________

1. Who is your Primary Care Provider (General Practitioner)? ___________________________
   a. City, State: _____________________________________
2. Did a physician refer you to our office for today's appointment? Yes or No
   a. By whom were you referred? ______________________________
3. Alcohol history: Do you consume alcohol? Yes or No
   a. Do you generally consume more than 5 drinks per sitting? Yes or No
4. Smoking history: (please circle one) Current Former Never
5. Did you receive the flu vaccination before/during this past flu season? Yes or No
6. Have you ever received the pneumonia vaccine? Yes or No
7. Do you have a living will? Yes or No

   If yes, do you have a Power of Attorney (POA)? Yes or No

   If yes, name of your POA? __________________________________
8. Do we have your permission to import your pharmacy records to help coordinate your care? Yes or No

   Preferred Local Pharmacy __________________________________

Office Use Only:

- **Visit Date:**
- **History Taken By:**