PATIENT INTAKE FORM

Please answer the following questions so we can comply with Medicare at our practice. Please bring this sheet with you into the exam room. Thank You.

Name _____ **Today's Date** _____

Date of Birth _____

Referred by: (Please circle)

Doctor Family Friend ZocDoc Website Google Facebook Other

1. Do you have any of the following?

   - Congestive Heart Failure (CHF) YES or NO
   - Coronary Artery Disease (CAD) YES or NO
   - Chronic Obstructive Pulmonary Disease (COPD) YES or NO
   - Diabetes (DM) YES or NO

2. How many times in the last 12 months have you had 4 or more alcohol drinks in one day? _____
3. Do you smoke tobacco? YES or NO
4. Did you receive the flu vaccine? YES or NO
5. Have you ever received the pneumonia vaccine? YES or NO
6. Do you have a surrogate? YES or NO. Please List _____
7. Who is your Primary Care Physician? _____

Month and Year of **Last Visit**_____

8. Medical Allergies: _____
9. Past Medical Problems: _____
10. Please list all your current medications (Please specify dose and frequency)

_____

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