OVER 65 INTAKE FORM

PATIENT NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____

Please answer the following questions so we can comply with the measures needed at our practice (**to be conducted once a quarter**). Please bring this sheet with you into the exam room. Thank You

1) Do you have any of the following?
    - Heart Failure
    - Coronary Artery Disease (CAD)
    - Chronic Obstructive Pulmonary Disease (COPD)
    - Diabetes
2) Did you receive the flu vaccine before this past flu season? ☐ **Yes** ☐ **No**
3) Have you ever received the pneumonia vaccine? ☐ **Yes** ☐ **No**
4) Do you have a history of Melanoma? ☐ **Yes** ☐ **No**
5) Are you a former or current smoker? ☐ **Yes** ☐ **No**
    If former what year did you quit? _____
6) How many times in the past year have you had 4 or more alcoholic beverages in **one** day? _____
7) Do you have a surrogate (someone we can discuss your medical records with)? If yes, who_____
8) Who is your Primary Care Physician? _____
    Month and Year of last visit: _____