Jennifer Perone, MD
Sarah Weitzul, MD
Priya Zeikus, MD

Patient Name:	Date of Birth:	Date of Service:

Do you have an Advanced Care Plan (Living Will)? ☐ YES ☐ NO
IF YES: Please name your Surrogate Decision Maker? ____________________________
☐ Please check this box if you are unable to or choose not to name your Surrogate Decision Maker

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Have you received an Influenza Immunization this year?
☐ YES ☐ NO Approximate Date: ___________________________

Have you EVER (in your entire life) received a Pneumococcal Vaccination?
☐ YES ☐ NO Approximate Date: ___________________________

Please list your HEIGHT:__________ AND WEIGHT:__________
(For Internal Use Only):
BMI Score:_____ ___Normal (18.5-24.9) ___Abnormal(25.0-29.9) ___Abnormal(30..0+)

Have you provided our office with a list of current medications? ☐ YES ☐ NO
Do you provide consent for us to retrieve/import medications from your pharmacy? ☐ YES ☐ NO

Tobacco use: ☐ Current smoker ☐ Former smoker ☐ Non-smoker
If former smoker, approximate date stopped: _____________________

Do you drink alcohol?
☐ YES ☐ NO Drinks per week ______________________________

Date of last mammogram (if applicable): ______________________

Have you had a colorectal screening? ☐ YES ☐ NO Approximate date: ___________________________

Who is your primary care physician? ______________________________ **Phone:** ____________________________

(For Internal use only):
BP:________ ____Normal (both sys/dia below 140/90) ___Abnormal(either systolic or diastolic above 140/90)