Documentation for flu, pneumonia, smoking, and care plan

The federal government is requiring all physicians to start collecting the information below.

We appreciate your cooperation

Additional Patient History Information

Name:_____ Date:_____

FOR ALL PATIENTS

- Has the patient received a flu vaccination for the current season?
  (This applies October through March only) Yes_____No_____
- If No, What is the reason? ____ Allergic ____Patient declined ____Vaccine unavailable
- Do you use tobacco products? Yes____No _____
- If Yes, how much and what products? _____

FOR THOSE PATIENTS 65 YEARS OF AGE OR OLDER

- Have you had a pneumonia vaccination? Yes____ No____
- Do you have a living will or Power of attorney? Yes_____No____

If yes, list their name, relationship and contact number

Name:_____Relationship:_____ Phone#_____

- Do you have a Health care proxy? Yes_____No____

Name:_____Relationship:_____ Phone# _____

***Signature _____**