



Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Surgical History		
Where	When	What

Recent Hospitalizations/ER Visits (past 3 months)		
Where	When	Why

Please list any specialists that you are currently seeing, or have seen in the past two years		
Name	Specialty	Last Visit

Smoking History:	Immunizations (shots)	
Never Smoked    Y    N	Type	Date
Current smoker    Y    N	Flu	
Former smoker    Y    N	Td/tdap	
Chew/Dip/Snuff    Y    N	Pneumonia	
Vape/e-cigarettes    Y    N	Shingles (zostvax/shingrix)	
Age when started ___ years		
Age when quit ___ years		
Average number of packs per day _____		

**Date of most recent:**

Dental Exam: \_\_\_\_\_ Eye Exam: \_\_\_\_\_  
 Labs: \_\_\_\_\_ Bone Density: \_\_\_\_\_  
 Pap Smear: \_\_\_\_\_ Mammogram: \_\_\_\_\_  
 Colonoscopy: \_\_\_\_\_  
 Other (EKG, Ultrasound, CAT Scan, MRI): \_\_\_\_\_

Are you sexually active?     Yes     No                      Are you interested in HIV testing?     Yes     No  
 Do you use alcohol or drugs of any kind?     Yes     No                      Do you consume Caffeine?     Yes     No

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Pediatric Patients Only:**

Patient was born at how many weeks? \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Length: \_\_\_\_\_

Place of Birth: \_\_\_\_\_     Cesarean     Vaginal

Are the patient's immunizations up to date?     Yes     No

Do you give permission for us to access the patient's state immunization record (NYSIIS)?     Yes     No