

Date: \_\_\_\_\_ Chart# \_\_\_\_\_

Patient Name: \_\_\_\_\_ D.O.B \_\_\_\_\_

Race \_\_\_\_\_

Language: \_\_\_\_\_

Ethnicity: PLEASE CHECK ONE  
\_\_\_\_\_ Hispanic  
\_\_\_\_\_ Non Hispanic  
\_\_\_\_\_ Decline

Smoking History:

YES - How many packs per day? \_\_\_\_\_ Years? \_\_\_\_\_

No - Quit when? \_\_\_\_\_ Never smoked? \_\_\_\_\_

Alcohol History:

Yes - How often? \_\_\_\_\_  
No

Drug allergies ? \_\_\_\_\_  
\_\_\_\_\_

Have you had the Pneumonia vaccine? Yes If Yes: When? \_\_\_\_\_  
No

Reason for today's visit ?  
\_\_\_\_\_  
\_\_\_\_\_