RENAL MEDICAL ASSOCIATES

THIS FORM MUST BE COMPLETED PRIOR TO THE APPOINTMENT. MAKE SURE AND BRING A LIST OF YOUR CURRENT MEDICATIONS AS WELL

NAME _____ DATE _____

DO YOU HAVE A LIVING WILL YES NO

DO YOU HAVE A POWER-OF-ATTORNEY YES NO

IF YES: WHO WILL MAKE DECISIONS FOR YOU IF YOU ARE UNABLE TO DO SO?
NAME _____
RELATIONSHIP TO YOU _____

DO YOU GET **FLU** VACCINES? YES NO
IF YES, ESTIMATED DATE OF LAST VACCINE _____
WHERE WAS THIS RECEIVED? PRIMARY CARE
PHARMACY
OTHER

DO YOU GET **PNEUMONIA** VACCINES? YES NO
IF YES, ESTIMATED DATE OF LAST VACCINE _____

DO YOU **CURRENTLY** USE TOBACCO PRODUCTS? YES NO
CIGARETTES
CIGARS
CHEWING TOBACCO

HOW MANY PACKS A DAY? _____
HOW MANY YEARS HAVE YOU SMOKED? _____

HAVE YOU FORMERLY USED TOBACCO PRODUCTS? YES NO
WHAT YEAR DID YOU QUIT? _____