

Dear Patient,

Welcome to Westpointe Medical, a division of Caldwell UNC Healthcare. Thank you for considering us as your healthcare provider. In order to allow our staff and practitioners to focus their energy on your healthcare needs, please take a few minutes to read and fully complete the enclosed packet of information.

Please be sure to bring your completed packet back to our office **at least** three days prior to your appointment. If for any reason you have not completed and returned this packet at that time, our office will contact you to have it brought in by the end of that business day. **Failure to do** so will result in your appointment being canceled and rescheduled for a later date.

As a courtesy, two days prior to your appointment, our office will send out a reminder call regarding your appointment date and time.

(Please provide an **accurate** phone number for contact purposes.)

In addition to the forms on your medical history, please fill-out the release of information form found on the Westpointe Medical website (<http://caldwellmemorial.org/office/53-westpointe-medical-practice>) indicating your current primary care provider so that we may request all previous medical records before your first visit with us.

Westpointe Medical Practice... 2651 Morganton Blvd., Lenoir, NC 828 -757-8950

Important Information for New Patients

We are a **Patient Centered Medical Home**, meaning we focus on:

- Enhancing Patient Experience
- Improving Population Health
- Reducing Costs
- Improving Provider and Staff Work Life

We want to partner with you and your family to understand and respect your unique needs, culture, values, and preferences. Along with your physician and other healthcare providers, you are the most important person in managing your health!

MEDICAL RECORDS

The patient portal, MyUNCCChart, is the best way to manage personal health records. See information within this packet or ask the front-desk how to sign-up at your first visit!

Your medical records may also be obtained through the office by signing a release of information form and in some instances- if the records are sent to another healthcare provider, a form is not required. We are happy to transfer your records to other healthcare providers per your request.

MAKING AND CANCELING APPOINTMENTS

Appointments may be scheduled through the office or via MyUNCCChart.

- Patients who present to the clinic 15 minutes *after* the appointment time for clinic visits and arrival time for procedures will be considered **late**.
- Patients who do not attend their scheduled appointment will be considered **no-show patients**.
- Patients who notify a member of the department scheduling staff *more than 24* hours before their scheduled appointment to cancel the appointment via MyChart note, phone call, in person, voicemail, or vendor (e.g., TeleVox) appointment reminder responses are considered a **patient cancellation**.
- Patients who notify a member of the scheduling staff *less than 24* hours before their scheduled appointment to cancel the appointment via MyChart note, voice mail, in-person, or phone call are consider a **same-day patient cancellation**.
- For the first and second occurrences of same-day cancellations and no-shows, patients will be given notified via phone call and/or letter. Patients who no-show, arrive late (and cannot be accommodated the same day), or cancel within 24 hours of the scheduled appointment **three times within 12 months** with an individual clinic or provider, may be dismissed from the provider's or discipline's clinic. All patient dismissals are made at the provider's discretion.
- It is the responsibility of the patient to:
 - Arrive for their scheduled appointment at the instructed arrival time to insure timely operation of the clinic and a positive experience for themselves and other patients. Late patients are not guaranteed to be seen for their scheduled appointment and may need to be rescheduled.
 - Notify the scheduling department as early as possible of a cancellation so they can be rescheduled and the slot can be available to other patients

It is of utmost importance to Westpointe Medical that your appointments are kept so that we are able to work together to improve and maintain your health. Because we value your time and health, we enforce a No-Show Policy consistently with all patients. Patients who miss an appointment without prior notification to the office may pose a risk to not only their own health, but also may pose a risk to other members of the community.

MAKING AND CANCELING APPOINTMENTS CONTINUED

We understand that conflicts arise and ask you notify us as soon possible; we will always do our best to reschedule your appointment. We truly value our communication with you, it is key to managing your health needs. Questions regarding no-shows and cancellations should be directed towards the practice manager and/or office nurse case manager.

REFERRALS

Your provider and care team will coordinate referrals for specialty care and diagnostic referrals.

CLINICAL ADVICE & PRESCRIPTION REFILLS

During office hours, contact the office and follow the prompts to speak with the clinical staff or request a prescription refill. For non-urgent clinical advice or prescription refills, you may also send a request through My UNC Chart. Patients have access to extended hours care through Caldwell Memorial Hospital's PLUS Urgent Care services and after-hours care by contacting Caldwell Memorial Hospital (828-757-5100) and asking for the provider on-call.

CALDWELL'S PLUS URGENT CARE OFFICES

Blowing Rock Medical Park PLUS Urgent Care

8439 Valley Blvd.

MON-FRI 8:00A-6:00P

Blowing Rock, N.C. 28605

SAT-SUN 10:00A-6:00P

Anderson Medical Park PLUS Urgent Care

270 Pine Mountain Rd., Suite 4

MON-FRI 8:00A-7:30P

Hudson, NC 28638

SAT-SUN 10:00A-6:00P

Rivercrest Medical Park PLUS Urgent Care

160 River Bend Dr. Ste. A

MON-FRI 8:00A-7:30P

Granite Falls, NC 28630

SAT-SUN 10:00A-6:00P

Robbins Medical Park PLUS Urgent Care

322 Mulberry St. SW

MON-FRI 8:00A-7:30P

Lenoir, NC 28645

SAT-SUN 10:00A-6:00P

PLUS Urgent Care is available on holidays at Anderson Medical Park 8:00 a.m. - 4:00 p.m. and Blowing Rock Medical Park 8:00 a.m. 12:00 p.m.

NOTICE: NORTH CAROLINA CONTROLLED SUBSTANCE REGISTRY

Because of the enormous problem of misuse of prescription drugs, North Carolina's Department of Health and Human Services maintains a website that tracks prescriptions including controlled substances like narcotics and sedatives. Examples of those medications include Valium, Percocet, OxyContin, Vicodin, Xanax, Lortab, Etc.

The Providers (Doctor's, Physician Assistants, and Family Nurse Practitioners) utilize this website to screen and confirm all medications that have been prescribed to patients seeking care in this Clinic. This website assists the providers in providing safe, effective medication management for patients.

Additionally, the providers do not provide pain management services for chronic conditions. **If** you are under another doctor's care for pain management, then additional pain medications will not be prescribed.

Caldwell UNC HealthCare complies with all applicable laws governing healthcare. For questions or clarification, please call Risk Management at 828-757-5456.

myUNC Chart™

STAY WELL

CONNECTED

More health care. *Online. All the time.*

Now more than ever, *My UNC Chart* allows you access to your UNC care team and your medical records all in one, secure, easy-to-use online portal.



Connect with
your provider



Pay bills
online



Access
test results



Manage accounts
of loved ones



Manage your
appointments



Get the **MyChart**
mobile app



Request
prescription refills



Track
your health

SIGN UP *to GET CONNECTED NOW at* **MYUNCCHART.ORG**

NEW PATIENT MEDICAL HISTORY & DEMOGRAPHICS

Full Name: First Middle Last									
Birth Date: MM / DD / YYYY				Age:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		SSN #:	
Preferred Provider/Physician:						Today's Date: MM / DD / YYYY			
How did you hear about us?					Name of patient if referred by patient currently being seen by practice (optional):				
Contact Information:									
Mailing Address:							City:		
State:		Zip:		Primary Phone:			<input type="checkbox"/> (H)ome <input type="checkbox"/> (W)ork <input type="checkbox"/> (C)ell		
Secondary Phone: <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W				Other Phone: <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W					
E-mail:				Emergency Contact Name:					
Emergency Contact Relation:				Emergency Contact Number: <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W					
Employment:									
1. Occupation: (or most recent): _____ Employer: _____				Current Employment Status:			<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Disabled		
2. Additional Occupation if more than one: _____ Employer: _____				Additional Employer Status:			<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Disabled		
3. Retirement Date: _____ <input type="checkbox"/> N/A				4. Do you work nightshift? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A					
Other:									
1. Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married				<input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner			2. Race: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Unknown/Other Race <input type="checkbox"/> White/Caucasian		
3. Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Unknown				4. Preferred Language:					
Insurance Information:									
Primary Insurance					Secondary Insurance				
Member #/ID for patient:					Member #/ID for patient:				
Group #:					Group #:				
Subscriber Name (name on card):					Subscriber Name (name on card):				
Subscriber Birthdate:					Subscriber Birthdate:				
Relationship to Patient:					Relationship to Patient:				
Complete if patient is a minor or if you are healthcare power of attorney (HCPOA): <i>Documentation for HCPOA must be provided with new patient paperwork...</i>									
1. Primary Caregiver Name:			2. Primary Caregiver DOB:			3. Is Primary Caregiver Guarantor? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Primary Caregiver's Relation:			5. Primary Caregiver Phone: <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W						
6. Secondary Caregiver Name:			7. Secondary Caregiver DOB:			8. Is Secondary Caregiver Guarantor? <input type="checkbox"/> Yes <input type="checkbox"/> No			
9. Secondary Caregiver's Relation:			10. Secondary Caregiver Phone: <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W						

Patient Name: _____

DOB: _____

Allergies List all to include food, animals, drug, etc. <input type="checkbox"/> NO ALLERGIES	
Allergy	Allergic Reaction
1.	
2.	
3.	
4.	

Medications Include ALL over the counter (i.e. Aspirin) & Prescriptions <input type="checkbox"/> NO MEDICATIONS		
Pharmacy:		Pharmacy City:
Medication (Please List All)	Dose (Mg, pill, etc.)	Frequency (Times Per Day/ Hour/ Week)
1.		<input type="checkbox"/> As Needed <input type="checkbox"/> Day <input type="checkbox"/> Hr <input type="checkbox"/> Wk
2.		<input type="checkbox"/> As Needed <input type="checkbox"/> Day <input type="checkbox"/> Hr <input type="checkbox"/> Wk
3.		<input type="checkbox"/> As Needed <input type="checkbox"/> Day <input type="checkbox"/> Hr <input type="checkbox"/> Wk
4.		<input type="checkbox"/> As Needed <input type="checkbox"/> Day <input type="checkbox"/> Hr <input type="checkbox"/> Wk
5.		<input type="checkbox"/> As Needed <input type="checkbox"/> Day <input type="checkbox"/> Hr <input type="checkbox"/> Wk
6.		<input type="checkbox"/> As Needed <input type="checkbox"/> Day <input type="checkbox"/> Hr <input type="checkbox"/> Wk
7.		<input type="checkbox"/> As Needed <input type="checkbox"/> Day <input type="checkbox"/> Hr <input type="checkbox"/> Wk
8.		<input type="checkbox"/> As Needed <input type="checkbox"/> Day <input type="checkbox"/> Hr <input type="checkbox"/> Wk

Please write additional medications on a blank sheet of paper with dose and frequency.

Medical History Indicate whether you have experienced difficulties "Current," "Past," or "Never" with the following conditions...				
Disease/Condition	Current	Past	Never	Comments
1. Alcoholism				
2. Anxiety				
3. Asthma				
4. Bipolar				
5. Cancer				Type:
6. Depression				
7. Diabetes				
8. Drug Abuse				Type:
9. Emphysema (COPD)				
10. Heart Disease				

Patient Name: _____

DOB: _____

Disease/Condition	Current	Past	Never	Comments
11. High Blood Pressure (Hypertension)				
12. High Cholesterol				
13. Suicidal				
14. Thyroid Disease				<input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Unknown/Unspecified
15. Renal (Kidney) Disease				
16. Migraine Headaches				
17. Stroke				
18. Suicidal:				
19. Other:				
20. Other:				
21. Other:				

Surgeries | Please provide details to the best of your knowledge, your care team may request records as needed.

Type (Specify Left/Right)	Date	Provider & Facility
1.		
2.		
3.		
4.		
5.		
6.		

Women's Health History | Please provide details to the best of your knowledge, your care team may request records as needed.

1. Date of Last Menstrual Cycle:	<input type="checkbox"/> N/A	6. Pregnancy Complications:	
2. Age of First Menstruation:	<input type="checkbox"/> N/A	7. Obstetric History:	
3. Age of Menopause:	<input type="checkbox"/> N/A	8. Date of Last Pap Smear	
4. # of Live Births:		9. Result of Pap Smear:	
5. Total # of Pregnancies:		10. Date of Last Mammogram:	

Patient Name: _____

DOB: _____

FAMILY MEDICAL HISTORY | *No Significant Family History Known*

CHECK <u>ALL</u> THAT APPLY	Alcohol Abuse	Drug Abuse	Asthma	Cancer	Emphysema (COPD)	Anxiety	Depression	Bipolar	Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other: _____	Other: _____	
	1. Mother																				
2. Father																					
3. Brother/s																					
4. Sister/s																					
5. Son																					
6. Daughter																					
7. Maternal Grandmother																					
8. Maternal Grandfather																					
9. Paternal Grandmother																					
10. Paternal Grandfather																					
11. Other: _____																					

Review of Systems | Check if significant problems within the last 3 mos.

Skin		Ears		Eyes	
<input type="checkbox"/> Y <input type="checkbox"/> N	Rash	<input type="checkbox"/> Y <input type="checkbox"/> N	Loss/Decrease Hearing	<input type="checkbox"/> Y <input type="checkbox"/> N	Blurry Vision
<input type="checkbox"/> Y <input type="checkbox"/> N	Sores	<input type="checkbox"/> Y <input type="checkbox"/> N	Drainage from Ears	<input type="checkbox"/> Y <input type="checkbox"/> N	Drainage from Eyes
<input type="checkbox"/> Y <input type="checkbox"/> N	Changes with a Mole	<input type="checkbox"/> Y <input type="checkbox"/> N	Ringing	<input type="checkbox"/> Y <input type="checkbox"/> N	Pain
<input type="checkbox"/> Y <input type="checkbox"/> N	Itching/Dryness	<input type="checkbox"/> Y <input type="checkbox"/> N	Earache	<input type="checkbox"/> Y <input type="checkbox"/> N	Vision loss/changes
<input type="checkbox"/> Y <input type="checkbox"/> N	Hair or Nail Changes			<input type="checkbox"/> Y <input type="checkbox"/> N	Flashing lights/dots
Lungs		Heart		Skeleton	
<input type="checkbox"/> Y <input type="checkbox"/> N	Cough	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Murmur/ Palpitations	<input type="checkbox"/> Y <input type="checkbox"/> N	Pain in Joints
<input type="checkbox"/> Y <input type="checkbox"/> N	Difficulty/painful breathing	<input type="checkbox"/> Y <input type="checkbox"/> N	Chest pains/discomfort/ tightness	<input type="checkbox"/> Y <input type="checkbox"/> N	Stiffness
<input type="checkbox"/> Y <input type="checkbox"/> N	Coughing up Blood	<input type="checkbox"/> Y <input type="checkbox"/> N	Swelling	<input type="checkbox"/> Y <input type="checkbox"/> N	Swollen Joints
<input type="checkbox"/> Y <input type="checkbox"/> N	Wheezing	<input type="checkbox"/> Y <input type="checkbox"/> N	Leg Pain when Walking	<input type="checkbox"/> Y <input type="checkbox"/> N	Back Pain
Gastro		Urinary		Neurologic	
<input type="checkbox"/> Y <input type="checkbox"/> N	Change in Appetite	<input type="checkbox"/> Y <input type="checkbox"/> N	Frequency	<input type="checkbox"/> Y <input type="checkbox"/> N	Dizziness
<input type="checkbox"/> Y <input type="checkbox"/> N	Problems Swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N	Urgency	<input type="checkbox"/> Y <input type="checkbox"/> N	Fainting
<input type="checkbox"/> Y <input type="checkbox"/> N	Abdominal Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Burning or Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Seizures
<input type="checkbox"/> Y <input type="checkbox"/> N	Wheezing	<input type="checkbox"/> Y <input type="checkbox"/> N	Blood in Urine	<input type="checkbox"/> Y <input type="checkbox"/> N	Weakness
<input type="checkbox"/> Y <input type="checkbox"/> N	Nausea/diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N	Incontinence	<input type="checkbox"/> Y <input type="checkbox"/> N	Numbness
<input type="checkbox"/> Y <input type="checkbox"/> N	Change in bowel habits	<input type="checkbox"/> Y <input type="checkbox"/> N	Change in Urinary Strength	<input type="checkbox"/> Y <input type="checkbox"/> N	Tingling
<input type="checkbox"/> Y <input type="checkbox"/> N	Rectal Bleeding			<input type="checkbox"/> Y <input type="checkbox"/> N	Tremor
<input type="checkbox"/> Y <input type="checkbox"/> N	Constipation				
Endocrine		Head		Psychiatric	
<input type="checkbox"/> Y <input type="checkbox"/> N	Heat/Cold Intolerance	<input type="checkbox"/> Y <input type="checkbox"/> N	Headaches/Migraines	<input type="checkbox"/> Y <input type="checkbox"/> N	Nervousness
<input type="checkbox"/> Y <input type="checkbox"/> N	Sweating	<input type="checkbox"/> Y <input type="checkbox"/> N	Neck Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Stress
<input type="checkbox"/> Y <input type="checkbox"/> N	Thirst	<input type="checkbox"/> Y <input type="checkbox"/> N	Head Injury	<input type="checkbox"/> Y <input type="checkbox"/> N	Depression
<input type="checkbox"/> Y <input type="checkbox"/> N	Change in Appetite			<input type="checkbox"/> Y <input type="checkbox"/> N	Memory Loss
Breast		Vaginal		Prostate	
<input type="checkbox"/> Y <input type="checkbox"/> N	Lump(s)	<input type="checkbox"/> Y <input type="checkbox"/> N	Discharge	<input type="checkbox"/> Y <input type="checkbox"/> N	Lump(s)
<input type="checkbox"/> Y <input type="checkbox"/> N	Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Hot Flashes	<input type="checkbox"/> Y <input type="checkbox"/> N	Pain with Sex
<input type="checkbox"/> Y <input type="checkbox"/> N	Discharge	<input type="checkbox"/> Y <input type="checkbox"/> N	Change in Periods	<input type="checkbox"/> Y <input type="checkbox"/> N	Lesions/Sores
<input type="checkbox"/> Y <input type="checkbox"/> N	Tenderness	<input type="checkbox"/> Y <input type="checkbox"/> N	Itching or Dryness	<input type="checkbox"/> Y <input type="checkbox"/> N	Loss of Sex Drive
<input type="checkbox"/> Y <input type="checkbox"/> N	Color Changes	<input type="checkbox"/> Y <input type="checkbox"/> N	Pain with Sex	<input type="checkbox"/> Y <input type="checkbox"/> N	Hernia
		<input type="checkbox"/> Y <input type="checkbox"/> N	Loss of Sex Drive		
		<input type="checkbox"/> Y <input type="checkbox"/> N	Lesions/Sores		

List other Problems Here:

Lifestyle			
1. Tobacco	Do you or have you used tobacco in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, move to alcohol use)		Type(s): <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Snuff <input type="checkbox"/> Chew <input type="checkbox"/> E-Cigarettes
	Current:	Packs /day: # of years:	Past: Quit Date: Packs /day: # of years:
2. Alcohol	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please move to drug use)		Drinks/day:
	Type(s): <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor		
3. Drugs	Do you use marijuana or recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: _____		
	Have you ever taken someone else's drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4. Sexual History	Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No		Partner(s) (current & past): <input type="checkbox"/> Male <input type="checkbox"/> Female
	Birth Control: <input type="checkbox"/> None <input type="checkbox"/> Condom <input type="checkbox"/> Pill <input type="checkbox"/> Ring <input type="checkbox"/> Patch <input type="checkbox"/> Injection <input type="checkbox"/> IUD <input type="checkbox"/> Vasectomy		
5. Exercise	Do you exercise regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, move to sleep.)		
	What kind of exercise?	Duration:	How long? _____ minutes Times/week: _____
6. Sleep	How many hours, on average, do you sleep per night/day (if nightshift worker)?		
7. Diet	How would you rate your diet? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
8. Safety	Do you use a bike helmet? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use seat belts consistently? <input type="checkbox"/> Yes <input type="checkbox"/> No	If you have guns, are they locked-up? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have a working smoke detector in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is violence at home a concern for you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you completed an Advanced Directive for Health Care, Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
9. Other	Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many? _____	

Additional Information	
1. Have you traveled outside of the country in the past 30 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify where: _____
2. Have you served in the military?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long & which branch? _____
3. Were you deployed?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify where: _____

Patient Name: _____
DOB: _____

Health Maintenance Screening History | Please provide details to the best of your knowledge, your care team may request records as needed.

Screening Item	Result	Date of Screening	Facility/Provider
1. Cholesterol	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown		
2. Colonoscopy /Sigmoid	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown		
4. Bone Density	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown		
5. Hep C	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown		
6. Eye Exam	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown		

Vaccination History | List to the best of your knowledge, your care team may need to request records of vaccines.

Vaccin	Date	Location:
1. Last Tetanus Booster/ TDAP		
2. Last Flu Vaccine		
3. Last Zoster Vaccine (Shingles)		
4. Last Pneumovax (Pneumonia)		
5.		
6.		

Other Providers/Specialists

Specialist	Name	Last Visit
1. Cardiology		
2. Gastroenterologist		
3. OB/GYN		
4. Neurology		
5. Pulmonary		
6. Other: _____		
7. Other: _____		