

Name	MRN#
Date	

Counseled patient: Yes \_\_\_\_\_

## PLEASE COMPLETE UPDATE AND COMPLETE THIS FORM BEFORE **EACH** OFFICE VISIT

Medication Name	Dosage (e.g., mg <b>)</b>	Frequency (how often)	Administration (oral, topical)	If changes made: Date of discontinuation or addition of medicine	
PLEASE UPDATE AND REVIE	EW AT EACH OFFI	ICE VISIT:			
Patient's Initials:	Date:	ĺ	Patient's Initials:	Date:	
Patient's Initials:	Date:	I	Patient's Initials:	Date:	
Patient's Initials:	Date:	I	Patient's Initials:	Date:	
TOBACCO USE: Do you use any tobacco products? Yes / No (please circle one)					
			Cou	unseled patient: Yes	
PNEUMONIA VACCINE: Ha (patients ≥ 65 years old)	ave you received	the Pneumonia	a vaccine? Yes/	No (please circle one)	