Medicare Questionnaire

Patient Name: _____ DOB: _____

Phone Number: _____ E-Mail: _____

Preferred Method of Contact:
[ ] Phone [ ] E-Mail

Primary Care Physician: _____
Referring Physician: _____

Preferred Pharmacy: _____

Have you ***ever*** received a pneumococcal vaccination? [ ] Yes [ ] No

Have you received a flu vaccination ***this season*** (Oct 1-Feb 28)? [ ] Yes [ ] No

Medication Name:	Dosage (mgs)	Frequency (once a day, etc)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____
14. _____	_____	_____
15. _____	_____	_____