ROCKLAND THORACIC & VASCULAR ASSOCIATES, P.C.
THORACIC AND CARDIOVASCULAR SURGERY

Patient Name: _____

Date of Birth: ____/____/____ Account #:_____

Please complete all sections below

Pneumonia: Date of Immunization: ___/___/____ (approx. date)

- If you did not get the Pneumonia Vaccine please check this box ☐

Influenza: Date of Immunization: ___/___/____ (approx. date)

- *If you don't remember* the exact date please give approximate
- If you did not get the Influenza Vaccine please check this box ☐

Advanced Directive:

- Do you have an advanced directive (i.e. living will)? (please circle) Yes or No

Smoking History:

- _____Never ____Quit (what year) ____
- _____Currently (packs/day)_____ How many years?_____

Patient Signature: _____ Date:___/___/___

Thank you,

Rockland Thoracic & Vascular Associates

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