

Dermatology Associates, Inc.

Patient In-take Questionnaire

Please complete the following information and return to the front desk upon completion.

Who is your primary care/referring physician? _____

Please list any medication allergies: _____

Unhealthy Alcohol Use: Screening and Brief Counseling.

How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? _____

Influenza Vaccine (Check the option that best fits)

- Received a flu vaccine this flu season
- Did not receive a flu vaccine this flu season because of medical reasons
- Did not receive a flu vaccine this flu season due to personal preference

Pneumococcal Vaccine For patients 65 and older ONLY (Check the option that best fits)

- Received a pneumococcal vaccine (Pneumovax)
- Did not receive a pneumococcal vaccine

Do you smoke? Yes _____ No _____ if you answered yes, how many packs per day? _____ ppd.

Were you a smoke in the past? Yes _____ No _____

Current Medication list: (If a list was given within the last 6 months, note medication changes by attaching list or completing below)

Current Pharmacy: (Please include street and city)

Continued on back

Please circle if you have ever been diagnosed with or exposed to any of the following:

Syphilis

Tuberculosis (TB) active disease

Chickenpox (Varicella)

Hepatitis B (acute and chronic)

Hepatitis C (acute and chronic)

Hepatitis, other acute viral

Human immunodeficiency virus (HIV) infection

Lyme disease

MRSA

Staph

Strep

Syphilis, other than primary and secondary

(Patient name, printed)

(Date)