MARYLAND SKIN CARE CENTERS LLC
JAGADEESH KUMAR MD

Name:_____ Date of birth:_____

These are the quality measures that Medicare mandates us to collect and report to them.

1. Did you ever receive a Pneumonia vaccine – YES date:____/____/_____Type_____ NO.
   If you have not received it please contact your primary care doctor to administer this.

2. Did you ever receive a Shingles vaccine – YES date:____/____/_____Type_____ NO.
   If you have not received it please contact your primary care doctor to administer this.

3. Did you use Tobacco in last 24 months, YES?NO if yes how much per day _____.

4. Do you drink Alcohol YES/NO - How many drinks ___/Day ____/Week ____/Month.

5. Do you have any problems walking and have risk of falling YES/NO.

6. Did you ever have a screening test for Colon Cancer YES/NO Date of test _____/_____/_____.

   Results Normal/polyps/ others please write_____.
   If you have not received it please contact your primary care doctor to refer for this test.

7. In the case of emergency and if you are not in capacity to make decisions for your healthcare whom do you want to be the decision maker for your health care.
   Name;_____ Relation:_____.
   Phone:_____.

Visit between October 1 and March 31

8. Did you receive Influenza Vaccine this season YES/NO Date;_____/_____/_____.
   If you have not received it please contact your primary care doctor to administer this.

WOMEN

8. Did you ever have PAP test screening for Cervical Cancer YES/NO Date;_____/____/_____.
9. Did you have screening test for breast cancer YES/NO Date;_____/_____/_____.
   If you have not received it please contact your primary care doctor to refer for above tests.

Signature;_____Date;_____.