SUPPLEMENTAL PATIENT INTAKE FORM

Due to new requirements from the United States Department of Health and Human Resources, we are requesting that <u>all</u> patients complete the following questionnaire.									
PATIENT NAME:					TODAY'S DATE:				
DATE OF BIRTH	H:			SEX:	Male	Female			
MELANOMA:									
Have you ever l	YES	□ NO							
If <u>YES</u> , did you e	ever have an X-ray, Catsca	n, MRI, or Petscan?	☐ YES						
TOBACCO USE	<u>:</u>								
Please choose t	he option that best descri	bes your tobacco use:							
Never	Less than 10	n 100 cigarettes in lifetime							
For <u>current tob</u>	acco users, select the opti	on that best describes use	:						
1-3 cigarette	es per day 🗌 Up t	o 1 pack per day	1-2 packs per day 2 or more packs a day						
ALCOHOL USE	<u>.</u>								
How often do y	ou have an alcoholic beve	rage?							
Never	Monthly or less	2-4 times per month	2-3 times	per wee	k 🗌	4+ times per week			
If you do drink,	how many drinks do you	typically have (based on 1	small glass of wi	ne or <u>hal</u>	<u>f a can </u> of bee	er)?			
☐ 1-2 On a single occa	☐ 3-4 asion in the last year, how	☐ 5-6 often have you had 3 <i>(fen</i>	☐ 7-9 nales) or 4 (males	s) drinks?	□10+ ?				
Never	Less than monthly	Monthly	Wee	ekly	Daily or	almost daily			

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SUPPLEMENTAL PATIENT INTAKE FORM (CONTINUED)

VACCINATIONS:

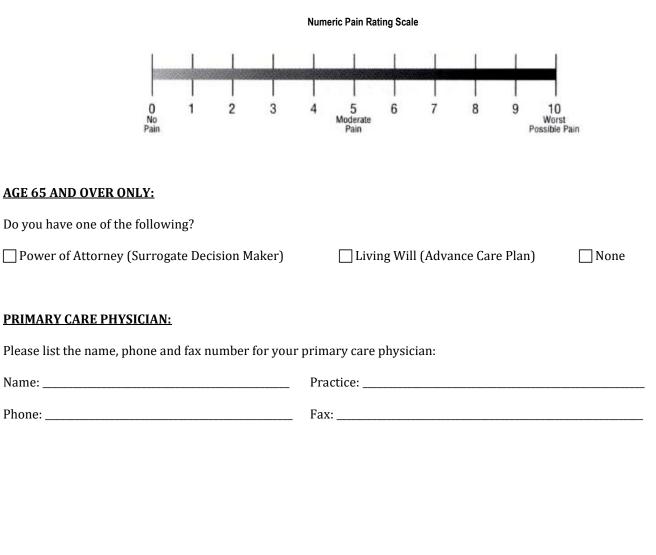
Between October 1st, 2019 and March 31st, 2020, did you receive the following vaccinations?

Flu vaccine:	YES	C	NO	
Pneumonia vaco	cine:	☐ YES		□ NO

PAIN:

Aside from general aches (i.e. muscle, head, tooth), are you currently experiencing any pain? 🗌 YES 👘 NO

If yes, please <u>circle</u> the number that corresponds with the amount of pain you are currently in:



FOR PHYSICIAN'S USE ONLY: SCORE: _____