SUPPLEMENTAL PATIENT INTAKE FORM

*Due to new requirements from the United States Department of Health and Human Resources, we are requesting that **all** patients complete the following questionnaire.*

PATIENT NAME: ______________________________ TODAY'S DATE: ________________

DATE OF BIRTH: ______________________________ SEX: ☐ Male ☐ Female

MELANOMA:

Have you ever been diagnosed with Melanoma? ☐ YES ☐ NO

If YES, did you ever have an X-ray, Catscan, MRI, or Petscan? ☐ YES ☐ NO

TOBACCO USE:

Please choose the option that best describes your tobacco use:

☐ Never ☐ Current smoker ☐ Previous smoker ☐ Less than 100 cigarettes in lifetime

For current tobacco users, select the option that best describes use:

☐ 1-3 cigarettes per day ☐ Up to 1 pack per day ☐ 1-2 packs per day ☐ 2 or more packs a day

ALCOHOL USE:

How often do you have an alcoholic beverage?

☐ Never ☐ Monthly or less ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4+ times per week

If you do drink, how many drinks do you typically have *(based on 1 small glass of wine or half a can of beer)?*

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+

On a single occasion in the last year, how often have you had 3 *(females)* or 4 *(males)* drinks?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ 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 ☐ NO

Pneumonia vaccine: ☐ YES ☐ NO

PAIN:

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

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

AGE 65 AND OVER ONLY:

Do you have one of the following?

☐ Power of Attorney (Surrogate Decision Maker) ☐ Living Will (Advance Care Plan) ☐ None

PRIMARY CARE PHYSICIAN:

Please list the name, phone and fax number for your primary care physician:

Name: ____________________ Practice: ____________________

Phone: ____________________ Fax: ____________________

FOR PHYSICIAN'S USE ONLY: *SCORE:* ____________ *INITIALS:* ____________