Westford Dermatolgy & Cosmetic Center

506 Groton Rd, Westford, MA 01886

PATIENT INTAKE FORM

NAME:____________________ DOB:______________

1.)DO YOU HAVE ANY OF THE FOLLOWING?

A. HEART FAILURE
B. CORONARY ARTERY DISEASE (CAD)
C. CHRONIC OBSTUCTIVE PULMONARY DISEASE (COPD)
D. DIABETES

2.)HAVE YOU RECEIVED THE FLU VACCINE BEFORE THIS PAST FLU SEASON?

3.)HAVE YOU EVER RECEIVED THE PNEUMONIA VACCINE? YES OR NO

4.)DO YOU HAVE A HISTORY OF MELANOMA? YES OR NO

5.)DO YOU SMOKE? YES OR NO

6.) WERE YOU A FORMER SMOKER? YES OR NO

7.) NUMBER OF ALCOHOLIC DRINKS PER DAY

NONE

1-2 PER DAY

3 OR MORE PER DAY

8.) ARE YOU CURRENTLY IN ANY PAIN? IF YES ON A SCALE FROM 1 (VERY LITTLE) TO 10 (EXTREMELY PAINFUL) WHAT IS YOUR PAIN LEVEL (NUMBER) ____________

9.) DO YOU HAVE AN ADVANCED CARE PLAN/ HEALTH CARE PROXY? YES OR NO

IF YES WHO IS DESIGNATED? ______________________________________

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