CENTER FOR
Dermatology &
Plastic Surgery

.

Patient name: _____ ***DOB:*** _____
Today's Date: _____ ***Email:*** _____

Smoking Status (Please choose one)

- ○ Current every day smoker
- ○ Current someday smoker
- ○ Former smoker
- ○ Never Smoked
- ○ Unknown if smoked

Number of packs per day: ____
Number of years smoked: ____

Vaccinations:

Have you received a flu vaccination within the last year? **Yes** **No**

If answered no, answer one of the following:

- ○ I am allergic to the vaccine
- ○ I do not want the flu shot
- ○ I have not received the flu shot because _____.

If over the age of 65, have you **ever** received a pneumonia vaccine? **Yes** **No**

Advanced Care Plan:

Do you have any of the following?

- ○ Medical Power of Attorney / Healthcare Proxy

Name: _____ Contact Number: _____

- ○ Living Will (Care plan)
- ○ Do Not Resuscitate
- ○ Do Not Intubate
- ○ Full Cardiac Resuscitation
- ○ **NONE**

_____
Signature of Patient or Patient's Legal Guardian