skin Science
CYNTHIA PRICE, M.D.

*Due to new requirements from the United States Department of Health and Human Resources, it is required that all patients complete the following questionnaire. This is a federal requirement and must be completed at each visit in order for you to be seen. Please refer to the Quality Measures handout if you have concerns regarding the reasoning behind why you are being asked these questions and directions on where to direct any complaints/concerns you may have.*

PATIENT NAME:_____ DOB: _____ TODAY'S DATE:

**PRIMARY CARE PHYSICIAN:**

Name:_____ Phone:_____

**ALCOHOL USE:**

Do you drink alcohol? ☐ Yes ☐ No If Yes: How many drinks per day?_____

**TOBACCO USE:**

Please choose the option that best describes your tobacco use:

☐ Never ☐ Current smoker ☐ Previous smoker

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

**VACCINATIONS: Have you received the following vaccinations?**

| | | |
|---|---|---|
| Flu vaccine in 2019 during Flu season: (January – March, October – December) | ☐ YES | ☐ NO |
| Shingles - Year: | ☐ YES | ☐ NO |
| HPV - Year: | ☐ YES | ☐ NO |
| Pneumonia vaccine Year: | ☐ YES | ☐ NO |

**ADVANCED CARE PLAN:**

Do you have one of the following?

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

Name/Relationship: _____

**DEPRESSION:**
Are you being treated for depression? ☐ Yes ☐ No If Yes: Provider name:_____

**PHARMACY:**
Preferred Pharmacy:_____

**By signing below, I attest that the above is true to the best of my knowledge**

_____
**Signature of Patient or Patient's Legal Guardian**