BROOKS DERMATOLOGY
MEDICAL · SURGICAL · COSMETIC

PATIENT INTAKE FORM

Please answer the following questions so we can comply at our practice. Thank you.

Name _____ **Date**_____

1) Do you have any of the following?
   - Congestive Heart Failure (CHF) YES or NO
   - Coronary Artery Disease (CAD) YES or NO
   - Chronic Obstructive Pulmonary Disease (COPD) YES or NO
   - Diabetes Mellitus (DM) YES or NO

2) Did you receive the flu vaccine before this past flu season? YES or NO

3) Have you ever received the pneumonia vaccine? YES or NO

4) Do you smoke tobacco? YES or NO

5) How many times in the last year (starting from 2018) have you had 4 or more alcoholic drinks in one day?

   _____

6) Who is your **Primary Care Physician** (PCP) and their **Office Phone Number**?

   _____

   Month and Year of **Last Visit**: _____

7) Medical Allergies:

   _____ _____ _____ _____

8) Past Medical Problems:

   _____ _____ _____ _____

9) Please list all your current medications (Please specify dose and frequency):

   _____ _____ _____ _____

   _____ _____ _____ _____

   _____ _____ _____ _____