

DERMATOLOGY & CUTANEOUS SURGERY, INC.
MICHAEL E. MCCADDEN, M.D., F.A.A.D.
LISA BURGARD, F.N.P.

Patient name _____ Date _____

Primary Care Doctor Name and phone number _____

Have you ever received a pneumococcal vaccination? _____

Did you receive a flu shot in the past year? _____

ALCOHOL USE

| | yes or no |
|---|-----------|
| Have you felt you should cut down on your drinking? | _____ |
| Have people annoyed you by criticizing your drinking? | _____ |
| Have you ever felt bad or guilty about your drinking? | _____ |
| Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? | _____ |

TOBACCO USE

Never used Current use Former use

If you have used or currently use tobacco please circle what form of tobacco you have used or still use.

cigarettes pipe cigar chew tobacco snuff other _____