BOONE DERMATOLOGY CLINIC
Nurses Intake Form
Return Patient

Patient Name_____ Today's Date:_____
Patient Date of Birth:_____

List all medications below; or, _____ I give permission to BDC to obtain from my pharmacy.

MEDICATION	**DOSAGE**	**FREQUENCY (How Often)**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ No change in medications from prior visit.

SOCIAL HISTORY:

Do you use alcohol? ____Yes ____No
If yes, how many times in the last year have you had more than 5 (for men) or 4 (for women or anyone over 65) or more drinks in a day?
___ unknown ___0 ___1 ___2 ___3 or more

Smoking Status:

___current every day smoker ___current some day smoker ___former smoker
___never smoker ___smoker, current status unknown ___unknown if ever smoked
___heavy tobacco smoker ___light tobacco smoker
Start Date: _____ End Date: _____

Flu/Pneumonia Vaccine:

Have you had a flu shot within the last year? ___Yes ___No
If yes, select location below and list date.
Administered at home (home health/pharmacy) Date: _____
Administered at work: Date: _____
If 65 or older, have you ever received a pneumonia vaccine? Date: _____

Shingles Vaccine:

Vaccine Date: _____

A1C:

Last Reading: _____
Date of Reading: _____

Please list any new allergies: _____

Please list any changes to medical history or any surgical procedures performed since last visit:

_____
_____
_____
_____
_____

Pregnant or planning a pregnancy? ___Yes ___No

Breast Feeding? ___Yes ___No

Pacemaker/Defibrillator? ___Yes ___No