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

Have you felt you should cut down on your drinking? yes or no

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______________________