Summit Plastic Surgery & Dermatology

Existing Patient History Intake Form

Patient Name:_____ DOB: ____ / ____ / _____

Have you had any changes in your medication since your last visit? (Please Circle) **YES** **NO**

If yes, please list changes:_____

_____

Have you had a flu vaccine this year? (Please Circle) **YES** **NO** If yes, date:_____

Have you had a pneumonia vaccine this year? (Please Circle) **YES** **NO** If yes, date:_____

Smoking Status: (Please circle the choice which applies)

- Every Day Smoker
- Some Days Smoker
- Former Smoker
- Never Smoked