Dermatology Associates of Central Florida
3670 Innovation Drive Lakeland, FL 33812
Phone: (863) 686-2282
Fax: (863) 686-2370

Intake Form

Patient Name: _____

Date of Birth: _____ Date of Visit: _____

1. Tobacco Use:

Non-Smoker ____ Previous Smoker ____

Smoker ____ How long? _____

*(**For office use only** , check box and provide initials to indicate smoking cessation was completed following specified guidelines _____)*

2. Number of alcoholic drinks per day:

_____ None

_____ Less than 1 per day

_____ 1-2 per day

_____ 3 or more per day

*(**For office use only** , check box and provide initials to indicate alcohol intervention was completed following specified guidelines _____)*

3. Do you have an Advance Care Plan/Directive?

____**YES** If yes, please list your Surrogate Decision Maker: _____

Phone # _____

____**YES** I wish to not indicate Surrogate Decision Maker

____ **NO**

4. Have you EVER had Pneumonia vaccine:

____ **YES** ____ **NO**

5. Have you received the flu vaccine for the current flu season: (Jan – March and/or Oct – Dec)

____ YES ____ NO

6. ***Who is your Primary Care Physician*** _____

Month & Year of your last visit _____