CHAPEL HILL DERMATOLOGY

Name _____ MRN# _____

Date _____

MEDICARE PATIENTS: Please complete update and complete this form before **each** office visit

Medication Name	Dosage (e.g., mg)	Frequency (how often)	Administration (oral, topical)	If changes made: Date of discontinuation or addition of medicine

PLEASE UPDATE AND REVIEW AT EACH OFFICE VISIT:

Patient's Initials: _____ Date: _____ Patient's Initials: _____ Date: _____

Patient's Initials: _____ Date: _____ Patient's Initials: _____ Date: _____

Patient's Initials: _____ Date: _____ Patient's Initials: _____ Date: _____

TOBACCO USE: Do you use any tobacco products? **Yes** / **No** (please circle one)

Counseled patient: Yes _____

PNEUMONIA VACCINE: Have you received the Pneumonia vaccine? **Yes/ No** (please circle one)
(patients over 65 years old)

Counseled patient: Yes _____