Affiliated Dermatologists, Inc.
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Medicare Health Questionnaire

Name: _____ DOB: _____ Date: _____

Have you had your **2020-2021** flu shot?	☐ YES Date:		☐ NO	
Did you have your **2019-2020** flu shot?	☐ YES Date:		☐ NO	
Have you had a Pneumonia Vaccine?	☐ YES Date:	☐ NO	Prevnar 13? ☐ YES	Pneumovax 23? ☐ YES
Have you had a Covid-19 Vaccine?	☐ YES 1st Date: 2nd Date:		☐ NO	
Are you a current smoker? (i.e., cigars, cigarettes, medical marijuana)	☐ YES Packs per day:		☐ NO	
Do you have a current medication list?	☐ YES (please provide a copy)		☐ NO (complete section below)	

Name of Drug	**Strength**	**Frequency**	**Route (i.e., oral, injection)**
Over the counter Medications, Supplements, Herbs, Vitamins			