KUFLIK DERMATOLOGY CENTER

453 Lakehurst Rd
Toms River, NJ 08755

150 E Kennedy Blvd.
Lakewood, NJ 08701

63 D Lacey Rd
Whiting, NJ 08759

2130 Rt 35 Ste A-113
Sea Girt, NJ 08750

1172A Beacon Ave
Manahawkin, NJ 08050

Patient Name: _____ DOB: _____ Date: _____

Medication Allergies and reaction: _____

Have you taken any Aspirin, Plavix, Coumadin, Pradaxa, Eliquis, Xarelto, Motrin, Advil, Fish Oil, or other pain relievers or arthritis medications in the last 2 weeks?

NO ____ YES ____ Please List: _____

(1– current medications documented) (**For office use only)**

NAME OF MEDICATION (PRESCRIPTION AND/OR OTC)	DOSAGE	TIMES PER DAY	METHOD OF ADMINISTRATION	REVIEWED & UPDATED DATE AND INITIAL

All Patients

Have you received the flu vaccine this year?

- ☐ Yes (2)
- ☐ No (Reason: _____ (3)

Do you have a history of Melanoma?

- ☐ Yes (4 and 5) (**not** Basal or Squamous Cell)
- ☐ No (6)

Are you on a biologic for a skin related condition? (ex: Stelara/Humira)

- ☐ Yes (7)
- ☐ No (8)

When did you last see your PCP? (primary Dr.)

_____

All Patients 12 and older

Tobacco Use:

- ☐ Non-Smoker (9) – 20 and younger-10)
- ☐ Smoker (11) – 20 and younger-12)

Patients 65 and older

Do you have an Advance Care Plan/Directive?

- ☐ Yes (13) If yes, please name your Surrogate Decision Maker: _____
- ☐ Decline to answer (14)

Have you EVER received the pneumonia vaccine?

- ☐ Yes (15)
- ☐ No (16)

(Staff Use Only) Reviewed with patient: _____