**HUNTERDON DERMATOLOGY, LLC**
**Christopher T. Cassetty, M.D.**

6 North Main Street
Flemington, NJ 08822

908-782-1647 phone
908-782-7296 fax

# MIPS Patient Intake Form

Patients of Hunterdon Dermatology, LLC,

Please help us continue to provide the best care we can, by assisting us with this form. Your cooperation is appreciated.

**Patient Name:** ______________________________ **Date:**______________

1. Do you have **any** of the following? Please **check** all that apply.
   - ○ Heart Failure
   - ○ Coronary Artery Disease (CAD)
   - ○ Chronic Obstructive Pulmonary Disease (COPD)
   - ○ Diabetes

2. Do you have a PCP (Primary Care Physician)?
   - ○ **Yes, I do have a PCP**
     - PCP Name: ______________________________
     - Month / Year of Last Visit:______________________________
   - ○ **No, I do not have a PCP**

3. Have you **ever** received the **pneumonia** vaccine? **YES** or **NO**
4. Did you receive the **flu** vaccine **this season**? **YES** or **NO**
5. Have you had the shingles vaccine? **YES** or **NO**

   **IF YES, PLEASE CIRCLE: Zostavax or Shingrix**

6. Do you smoke? **YES** or **NO**
7. How many times in the last year have you had 4 or more alcoholic drinks **in one day?**

   Please circle: **1 OR LESS** **2 OR MORE**

**Continued on back of page ...**

8. Do you have a healthcare proxy in the event you are unable to make your medical decisions?
    - **Yes, I do.**
        - Designee's Name: ______________________________
        - Phone Number : ________________________________
    - **No, I do not.**

9. Do you have a living will? **YES** or **NO**

10. IF YOU ANSWERED YES FOR QUESTION NUMBER 9, which statement best reflects your wishes on advanced care recommendations if something required a decision while in the office or on the property?
    - **Do not intubate: <u>I do not</u>** wish to have a breathing tube, even if it is necessary to save my life.
    - **Do not resuscitate:** If my heart were to stop, I **<u>do not</u>** wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.
    - **Full cardiopulmonary resuscitation**: I **<u>do</u>** want full cardiopulmonary resuscitation efforts to be made.

11. Do you have a history of cancer in your family?
    - **Yes, I do**. Please list the type below with your relationship to that person:

      ______________________________________________

      ______________________________________________

      ______________________________________________

      ______________________________________________
    - **No, I do not.**