SURGICAL DERMATOLOGY ASSOCIATES, P.A.

Jennifer Perone, MD, FAAD
Sarah Weitzul, MD, FAAD

2025 Quality Reporting

Patient Name:	Date of Birth:	Date of Service:

(Measure 47)

Do you have an Advanced Care Plan (Living Will)? ☐ **YES** ☐ **NO**

IF YES: Please name your Surrogate Decision Maker? _____

☐ Please check this box if you are unable or choose not to name your Surrogate Decision Maker.

(497 A)

Have you received Influenza Immunization from August 1st, 2024, to current?
☐ **YES** ☐ **NO** ***Approximate Date:***

(497 B)

Have you EVER (in your entire life) received a Pneumococcal Vaccination?

☐ **YES** ☐ **NO** ***Approximate Date:***

(497 E)

Please list your **HEIGHT: _____ WEIGHT: _____**

Have you provided our office with a list of current medications? ☐ **YES** ☐ **NO**

Do you provide consent for us to retrieve/import medications from your pharmacy? ☐ **YES** ☐ **NO**

(497 FA/FB/FC)

Tobacco use: ☐ Current smoker ☐ Former smoker ☐ Non-smoker

Do you drink alcohol?

☐ **YES** ☐ **NO** If yes, how many drinks per week?

(497 E)

Date of last mammogram (if applicable):

(497 D)

Have you had a colorectal screening? ☐ **YES** ☐ **NO** ***Approximate Date:***

(#317)

Have you ever been diagnosed with hypertension? ☐ **YES** ☐ **NO**

Signature of Patient/Legally authorized representative **Date** **Relationship**

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