

COSULICH DERMATOLOGY, LLC
HEALTH ASSESSMENT FORM - 2023

In accordance with CMS government guidelines (PQRS – Physician Quality Reporting System), we are required to obtain *annual* overall health assessments on our patients.

Print Name: _____ DOB: _____

Today's Date: _____

Fall Risk Assessment

Have you had any falls in the past year? No Yes

If yes, how many falls in the past year?

If yes, were you injured? No Yes

If injured, describe injury below:

I do not wish to discuss this matter

Vaccination Screening

Have you had a flu vaccine this season? No Yes

If yes, date of vaccination (MM/YY): ____/____

If no, reason:

___ Recommended but not administered

___ Refused – Do not want vaccine

___ Allergic to flu vaccine

If you are **over** 65 years of age, have you ever had the pneumococcal vaccination? No Yes _____ (YYYY)

I do not wish to discuss this matter

Diabetic Patient Screening

Are you diabetic? No Yes

If yes, what is your Hemoglobin A1C? Less than 7 Between 7 and 9 Greater than 9 Unsure

I do not wish to discuss this matter

Advance Directive (Living Will)

If you are 65 or over, do you have an advance directive (living will)? No Yes

If yes, please write the name of your Proxy (individual authorized to make medical decisions on your behalf – usually a spouse or child): _____

If no, would you like more information? No Yes I do not wish to discuss this matter