MIPS Intake Form

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle your response to the following questions. If Yes, please include the date.

1. Do you drink alcohol on a daily basis? YES NO
2. What is your current smoking status (tobacco)? CURRENT FORMER N/A
3. Do we have a list of your current medications? YES NO
4. Do we have a list of current allergies? YES NO
5. Have you previously been diagnosed with Hepatitis C? YES NO UNSURE
6. Have you previously received an immunization for Influenza? YES NO

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have an Advanced Care Plan or Living Will? YES NO
2. Who is your decision maker/surrogate for your Advanced Care Plan?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_