

Past Medical History: (please circle all that apply)

Alzheimer's/Dementia	Hepatitis
Anxiety	Hypertension
Arthritis	HIV/AIDS
Artificial joints	Hypercholesterolemia
Asthma	Hyperthyroidism
Atrial fibrillation	Hypothyroidism
BPH	Leukemia
Bone Marrow Transplantation	Lung Cancer
Breast Cancer	Lymphoma
Colon Cancer	Pacemaker
COPD	Prostate Cancer
Coronary Artery Disease	Radiation Treatment
Depression	Seizures
Diabetes	Stroke/TIA
End Stage Renal Disease	Valve Replacement
GERD	None
Hearing Loss	
Other	

Past Surgical History: (please circle all that apply)

Appendix Removed	Joint Replacement within last 2 years
Bladder Removed	Kidney Biopsy
Mastectomy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Lumpectomy (Right, Left, Bilateral)	Kidney Stone Removal
Breast Biopsy (Right, Left, Bilateral)	Kidney Transplant
Breast Reduction	Ovaries Removed: Endometriosis
Breast Implants	Ovaries Removed: Cyst
Colectomy: Colon Cancer Resection	Ovaries Removed: Ovarian Cancer
Colectomy: Diverticulitis	Prostate Removed: Prostate Cancer
Colectomy: IBD	Prostate Biopsy
Gallbladder Removed	TURP
Coronary Artery Bypass	Skin Biopsy
PTCA	Basal Cell Cancer Surgery
Mechanical Valve Replacement	Squamous Cell Carcinoma Surgery
Biological Valve Replacement	Melanoma Surgery
Heart Transplant	Spleen Removed
Joint Replacement, Knee (Right, Left, Bilateral)	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)	Hysterectomy: Fibroids
	Hysterectomy: Uterine Cancer
	None

Other _____

Skin Disease History: (please circle all that apply)

- Actinic Keratosis
- Basal Cell Skin Cancer
- Blistering Sunburns
- Melanoma
- Precancerous Moles
- Squamous Cell Skin Cancer
- None
- Other

Do you wear Sunscreen? Yes No
 If yes, what SPF? _____
 Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
 If yes, which relative(s)? _____

Any other family history:

- Non-Melanoma Skin Cancer** ---Mother---Father—Sister---Brother---Aunt---Uncle---Grandparents
(Basal or Squamous Cell Carcinoma)
- Other Cancer**---Mother---Father—Sister---Brother---Aunt---Uncle---Grandparents
- Diabetes**---Mother---Father—Sister---Brother---Aunt---Uncle---Grandparents
- Hypertension**---Mother---Father—Sister---Brother---Aunt---Uncle---Grandparents
- Cardiovascular Disease**---Mother---Father—Sister---Brother---Aunt---Uncle---Grandparents
- Arthritis**---Mother---Father—Sister---Brother---Aunt---Uncle---Grandparents
- Thyroid Disease**---Mother---Father—Sister---Brother---Aunt---Uncle---Grandparents
- Autoimmune Disease**---Mother---Father—Sister---Brother---Aunt---Uncle---Grandparents
- Depression**---Mother---Father—Sister---Brother---Aunt---Uncle---Grandparents

Medications: (Please enter all current medications, dosages, and frequency)

Allergies: (Please enter all allergies)

Social History: (Please circle all that apply)

Cigarette Smoking:

- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Alcohol Use: Yes / No

- Have you had a flu vaccination this year? Yes/No
- Have you had a pneumonia vaccination this year? Yes/No
- Do you have a healthcare surrogate? Yes/No
- Name of surrogate _____

Review of Systems: Are you currently experiencing any of the following?
 (please check yes or no for the following)

Symptom	Yes	No
Epinephrine- rapid heart beat		
Immunosuppression		
Problems with scarring		
Rash		
Diabetes		
Allergy to topical antibiotic ointments		
Changing mole		
Uses supplemental Oxygen		

Other Symptoms: _____

Alerts: Are you currently experiencing any of the following?
 (please check yes or no for the following)

Alert	Yes	No
Pacemaker		
Defibrillator		
Artificial joints within past 2 years		
Artificial heart valve		
Premedication prior to procedure		
Anti-Coagulant Medication		
Problems with bleeding		
Lidocaine allergy		
Epinephrine shock or dangerous reaction		
Latex allergy		
Allergy to adhesive		
Issues with buried sutures		
Pregnancy or planning pregnancy		
Renal dialysis		
Decreased renal function critical		
Impaired liver function cirrhosis		
HIV +		
HEPATITIS B/C		
H/O Leukemia/Lymphoma (please circle)		
History of cold sores/Oral HSV		
H/O Organ Transplant		
Breast Feeding		
H/O Melanoma		
H/O MRSA		
Memory loss issues		

Other Symptoms: _____