

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

Primary Care Physician: \_\_\_\_\_

Select any of the following medical conditions that you currently have:

- Anxiety
- Arthritis
- Asthma
- Irregular Heartbeat
- Enlarged Prostate
- Bone Marrow Transplantation
- Breast Cancer
- Colon Cancer
- Emphysema
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- Acid Reflux
- Hearing Loss
- Hepatitis
- High Blood Pressure
- HIV/AIDS
- High Cholesterol
- High Thyroid
- Low Thyroid
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- Other: \_\_\_\_\_
- None

Please list surgeries you have had:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had any of the following skin conditions?

- Acne
- Actinic Keratoses
- Multiple Moles
- Basal Cell Skin Cancer**
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Hay Fever/Allergies
- Melanoma**
- Poison Ivy

(Continued)

- Precancerous Moles
- Psoriasis
- Squamous cell skin cancer
- None

Family History of skin cancer:  
 (BCC, SCC)

Which family member?

\_\_\_\_\_

Melanoma: yes    no    maybe (circle one)

Which family member?

\_\_\_\_\_

Do you wear Sunscreen ? \_\_\_\_\_

If so, what SPF? \_\_\_\_\_

Have you ever tanned in a tanning salon? \_\_\_\_\_

Please list your current Medications:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list your Allergies to Medications:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please tell us your social history about:

Smoking:

- Never a smoker
- Former smoker
- Currently every day smoker
- Other: \_\_\_\_\_

Alcohol Use:

- Never
- Less than 1 drink per day
- 1-2 drinks per day
- 3 or more drinks per day

\*Please turn over, form continued on backside

**Review of Systems: Check any that apply to you:**

- Problems with bleeding
- Problems with healing
- Problems with scarring (hypertrophic or keloid)
- Immunosuppression
- Changing mole(s)
- Rash
- Abdominal pain
- Anxiety
- Cough
- Depression
- Fever or chills
- Headaches
- Hay fever
- Joint aches
- Muscle weakness
- Night sweats
- Seizures
- Shortness of breath
- Thyroid problems
- Unintentional weight loss
- Wheezing
  
- Pacemaker
- Defibrillator
- Artificial joints within past 2 years
- Artificial heart valve
- Premedication prior to procedures
- Allergy to adhesive
- Allergy to topical antibiotic ointments
- Blood thinner
- Pregnancy or planning pregnancy
- Allergy to lidocaine
- Rapid heartbeat with epinephrine
- Yeast infections with antibiotics
- GI upset with antibiotics
- Other: \_\_\_\_\_

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- None**

**West Africa: Travel or Contact**

- Ebola Risk: Fever  $\geq 100.4$ (F)/ 38 degrees (C)
- Ebola Risk: Resided or Traveled to country with wide-spread Ebola transmission in the last 21 days
- Ebola Risk: Contact with an Ebola patient without proper protective equipment within the last 21 days
- Ebola risk: Headaches, weakness, muscle pain, vomiting, diarrhea, abdominal pain, and/or hemorrhage

**Thank you ☺**