**Skin Disease History: (please <u>check</u> all that apply)**

☐ Acne
☐ Actinic Keratosis
☐ Asthma
☐ Basal Cell Skin Cancer
☐ Blistering Sunburns
☐ Dry Skin
☐ Eczema
☐ Flaking or Itchy Scalp
☐ Hay Fever/Allergies
☐ Melanoma
☐ Squamous Cell Skin Cancer
☐ Poison Ivy
☐ Precancerous Moles
☐ Psoriasis
☐ Rosacea
☐ 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: ___________________________________________

**Please List Current Medications & Vitamins**

Medication _________________________________ Dosage ______________ Frequency _______________
Medication _________________________________ Dosage ______________ Frequency _______________
Medication _________________________________ Dosage ______________ Frequency _______________
Medication _________________________________ Dosage ______________ Frequency _______________
Medication _________________________________ Dosage ______________ Frequency _______________

**Medication Allergies: (include reaction)**
Allergy: ________________ Reaction: _____________ Allergy:_________________ Reaction: ____________
Allergy: ________________ Reaction: _____________ Allergy:_________________ Reaction: ____________

**Social History: (please check all that apply)**
**Alcohol Use:** ☐ None ☐ <1 drink per day ☐ 1-2 drinks a day ☐ 3 or more drinks per day
**Cigarette Smoking:** ☐ Never ☐ Former smoker ☐ Smokes less than daily ☐ Smokes daily
**Illicit Drug Use:** ☐ Drug Use ☐ IV Drug Use
**Do you take an Anticoagulant Medication (blood thinner)?** ☐ Yes ☐ No If so, what medication?__________________________________

**Alerts:** Are you currently experiencing any of the following? **Please <u>check</u> yes or no**

| | | |
|---|---|---|
| **Allergy to adhesives** | ☐ **Yes** | ☐ **No** |
| **Allergy to lidocaine** | ☐ **Yes** | ☐ **No** |
| **Allergy to topical antibiotic ointments** | ☐ **Yes** | ☐ **No** |
| **Artificial heart valve** | ☐ **Yes** | ☐ **No** |
| **Artificial joints with past 2 years** | ☐ **Yes** | ☐ **No** |
| **Blood thinners** | ☐ **Yes** | ☐ **No** |
| **Defibrillator** | ☐ **Yes** | ☐ **No** |
| **History of MRSA** | ☐ **Yes** | ☐ **No** |
| **Pacemaker** | ☐ **Yes** | ☐ **No** |
| **Premedication prior to procedure** | ☐ **Yes** | ☐ **No** |
| **Rapid heartbeat with epinephrine** | ☐ **Yes** | ☐ **No** |
| **Pregnancy, planning a pregnancy or breast feeding** | ☐ **Yes** | ☐ **No** |
| **Immunosuppressed** | ☐ **Yes** | ☐ **No** |