

Select The Following Medical Conditions That You Currently Have or Have Had (Mark All That Apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Esophageal Reflux | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Transplant |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hyperthyroidism | |
| <input type="checkbox"/> Other: _____ | | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hypothyroidism | _____ |

Select Any Of The Following Skin Conditions That You Have Had (Mark All That Apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Poison Ivy |
| <input type="checkbox"/> Actinic Keratoses (Precancers) | <input type="checkbox"/> Eczema | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Squamous Cell Carcinoma |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Other: _____ |

Select Any Of The Following That You Have (Mark All That Apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergy to Adhesive | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Allergy to Lidocaine | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Premedication Prior to Procedures |
| <input type="checkbox"/> Allergy to Topical | <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Rapid HB with Epinephrine |
| <input type="checkbox"/> Antibiotic Ointment | <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Pacemaker |
| | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Planning Pregnancy |
| | | <input type="checkbox"/> Breastfeeding |

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? _____

Do you have a family history of Basal Cell Carcinoma or Squamous Cell Carcinoma? YES NO
If yes, which relative? _____

Are You Currently Or Have You Recently Experienced Any Of The Following (Mark All That Apply)

- Diarrhea Fatigue Unintentional Weight Loss Pain/Burning on Urination Nausea Night Sweats
- Weight gain New Onset of Joint Aches Vomiting Cough Depression Numbness/Weakness
- Fever or Chills Shortness of Breath Anxiety

Alcohol Use: None Less Than 1 Drink/Day 1-2 Drinks/Day 3 or More Drinks/Day

Smoking Status: Current Everyday Smoker Current Occasional Smoker Former Smoker Never Smoke

Patient or Patient Representative Signature

Date

Health Care Provider Signature

Date