Kaleidoscope Skin Clinic

Patient's full name: _____DOB: _____/_____/_____

Are you currently using any prescription creams, ointments, etc ☐ No ☐ Yes

Details: _____

_____

_____

Do you have any significant health conditions, or had any surgical procedures? ☐ No ☐ Yes

Details: _____

_____

_____

_____

_____

Do you take any medications, vitamins or supplements?

Details: _____

_____

_____

_____

_____

Are you allergic to any medications?

Details: _____

_____

_____

_____

Smoking history?

☐ Yes ☐No Details _____

Are you pregnant?

☐ Yes ☐No Details_____

Have you ever developed a rash or allergy to any antiseptics or dressings below ?

☐ Yes	☐ No	Alcohol	☐ Yes	☐ No	Alumium Chloride
☐ Yes	☐ No	Chlorhexadine	☐ Yes	☐ No	Steri-Strips
☐ Yes	☐ No	Betadine	☐ Yes	☐ No	Micropore
☐ Yes	☐ No	Kaltostat	☐ Yes	☐ No	Hypafix
☐ Yes	☐ No	Sutures	☐ Yes	☐ No	Other:_____
☐ Yes	☐ No	Opsite, Tegaderm, adhesive film	☐ Yes	☐ No	Other:_____

Signature

_____ Date: _____/_____/20_____

By signing this form, you certify that you have answered all questions truthfully and correctly to the best of your knowledge, and you understand and accept Kaleidoscope Skin Cancer Clinic's policies.

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