Please mark today’s visit: ____________________________

Please answer to the following questions to comply with The Medicare EHR Incentive Program.

Please mark all that apply:

<table>
<thead>
<tr>
<th>Condition/Reaction</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>1-2 per day</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>None</td>
</tr>
<tr>
<td>Hypertension</td>
<td>None</td>
</tr>
<tr>
<td>Cancer-Type:</td>
<td>None</td>
</tr>
<tr>
<td>Allergy to topical antibiotic/ointments</td>
<td>None</td>
</tr>
<tr>
<td>Allergy to adhesive</td>
<td>None</td>
</tr>
<tr>
<td>Allergy to Lidocaine</td>
<td>None</td>
</tr>
<tr>
<td>Require premedication prior to procedures</td>
<td>None</td>
</tr>
<tr>
<td>Experience rapid heartbeat with Epinephrine</td>
<td>None</td>
</tr>
<tr>
<td>Experience yeast infections with antibiotics</td>
<td>None</td>
</tr>
<tr>
<td>Experience G.I. upset with</td>
<td>None</td>
</tr>
<tr>
<td>Taking a blood thinner (Aspirin, coumadin, plavix etc)</td>
<td>None</td>
</tr>
</tbody>
</table>

Please list all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

- See attached list of medications.
- None

Please list any surgical procedures you have had in the past 6 months:

- None

Do you have a family history of the following?

- Diabetes: □ Mother □ Father
- Elevated Cholesterol: □ Mother □ Father
- High Blood Pressure: □ Mother □ Father

Did you receive a flu vaccine during this flu season? □ Yes □ No
Have you ever smoked in the past 2 years? □ Yes □ No
Did you drink alcohol? □ Yes □ No
If yes: □ less than 1 drink per day □ 1-2 per day □ More than 3 per day

Do you currently smoke tobacco? □ Yes □ No
Have you ever smoked in the past? □ Yes □ No
Do you use sunscreen regularly? □ Yes □ No
If yes, what SPF? ______

Do you have an allergy to Neosporin? □ Yes □ No

Please list the name of medication and type of reaction below.

- None

Are you allergic to any medications? □ Yes □ No
If yes, please list the name of medication and type of reaction below.

Please mark the skin conditions or disease that you currently have, or have had in the past:

- Acne
- Actinic Keratosis
- Blistering Sunburn
- Dry Skin
- Eczema
- Flaking/Itchy Scalp
- Poison Ivy
- Psoriasis
- Basal Cell Carcinoma
- Squamous Cell Carcinoma
- Precancerous Moles
- Melanoma
- Family history of melanoma?

Do you use sunscreen regularly? □ Yes □ No
If yes, what SPF? ______

Do you have an allergy to Neosporin? □ Yes □ No

Please mark the condition(s) or disease(s) that you currently have, or have had in the past:

- Arthritis
- Coronary Artery Disease
- Hypercholesterolemia
- Hypercholesterolemia (High Cholesterol)
- Hypertension
- Hypertension (High Blood Pressure)
- Cancer-Type:
- A-Fib (Irregular Heartbeat)
- GERD/Acid Reflux
- Hyperthyroidism
- Hypothyroidism
- None
- COPD/Emphysema
- Hepatitis
- Seizures
- Other:

Please list any surgical procedures you have had in the past 6 months:

- None

Do you use sunscreen regularly? □ Yes □ No
If yes, what SPF? ______

Do you have an allergy to Neosporin? □ Yes □ No

Please list the name of medication and type of reaction below.

- None

Are you allergic to any medications? □ Yes □ No
If yes, please list the name of medication and type of reaction below.

Please answer to the following questions to comply with The Medicare EHR Incentive Program.

What pharmacy do you use? ____________________________ City, State ____________________________

What is your preferred language: ____________________________

What is your race? □ White □ American Indian or Alaskan Native □ Black or African American
□ Asian □ Native Hawaiian or Other Pacific Islander □ Other

What is your ethnicity? □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown

Patient Signature: ____________________________ Date: ____________________________