Family History:

Does anyone in your family have a history of breast cancer? ☐ Yes ☐ No

If yes who? _____

Has anyone in your family had complications from anesthesia? ☐ Yes ☐ No

Do you have any other family history of medical problems (list problem and family member)?

_____

_____

Social History:

1. Have you ever ***Smoked Tobacco*** products or currently ***Vape***? ☐Yes ☐ No

   If Yes # of pack(s) per day? _____ # of years? _____

   If you quit when? _____

2. Do you drink alcohol? ☐ Yes ☐ No

   If Yes average # of drinks per day? _____ per week? _____

3. Do you use anyone else's prescription drugs or other drugs not prescribed by a physician? ☐ Yes ☐ No
   If Yes what? _____

4. *Have you taken Steroids within the last year*? ☐ Yes ☐ No
   If Yes, medication name: _____

Would you like a complimentary skin evaluation while you are here today? ☐ Yes ☐ No

Signature: _____ **Date:** _____