

SKIN PROTECTION:

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, Who in Family? _____

SOCIAL HISTORY:

Do you or have you ever used tobacco? ____ Yes ____ No

- Number of packs per day? _____
- Total number of years smoking? _____

Do you consume alcohol? ____ Yes ____ No

- How many drinks per day? _____

Do you use recreational drugs? ____ Yes ____ No

How often do you exercise? _____

Do you consume caffeine? ____ Yes ____ No

- How many times per day? _____

Do you feel safe at home? ____ Yes ____ No

Patient Signature _____ Date: _____