

Review of Systems: (please check yes or no)

Problems with healing: Yes No
Problems with scarring: Yes No
Blood Thinners: Yes No
Artificial Heart Valve: Yes No
History of MRSA: Yes No
Allergy/Sensitivity to Lidocaine: Yes No

Problems with bleeding: Yes No
Pacemaker/ Defibrillator: Yes No
Artificial Joints: Yes No
Immunocompromised: Yes No
Allergy/Sensitivity to adhesive: Yes No
Do you need antibiotics prior to surgery: Yes No

Merit-based Incentive Payment System (MIPS): (please fill out if over 65 years old)

Do you have a health care proxy to assist in making medical decisions on your behalf?

Yes No

List name of health care proxy: _____

Contact phone number of health care proxy: _____

Relationship of health care proxy to patient: _____

Do you have a living will or an advanced directive: Yes No

Please choose which statement(s) applies to your wishes regarding the advanced directive:

- Do Not Resuscitate (no CPR or defibrillator)
- Do Not Intubate (no breathing tubes)
- Intubate (breathing tube)
- Full Cardiopulmonary Resuscitation (CPR/defibrillator)