

Please fill out this form completely and bring to your surgery appointment.

PREOPERATIVE HEALTH INFORMATION FORM

Patient Name: _____ **Date:** _____

Age _____ Date of birth: _____ Gender: M F Marital status: S M D W Spouse name: _____

Primary dermatology provider (circle): Ayre Baird Blumberg Genest Glazer Ivker Lemiech Nadel Petros
Sher Wenner Other: _____

Location(s) of problem(s) for which you are being seen _____

How long has the problem been present? _____

Was there any previous treatment? Yes No When? _____ Type? _____

Was a biopsy done? Yes No

Mohs surgery patients: I have read the instructions on page 3 of the Mohs surgery patient handbook No Yes If not, please read these instructions before your surgery appointment.

Medical Conditions: _____

Previous major surgeries and dates (year): _____

Medications (Please list all prescription and over the counter medications, vitamins and herbals.): _____

Allergies to Medications None Yes (List medication and how you react):, _____

Are you allergic to latex? No Yes

Have you had any problems with local anesthesia or epinephrine? No Yes
If yes, what was the reaction? _____

Do you have a history of abnormal scarring or keloids? No Yes

Do you have a pacemaker? No Yes

Do you have an internal defibrillator? No Yes

Have you been advised to take antibiotics before dental work or surgery? No Yes

Do you have an artificial heart valve? No Yes

Do you have a history of bacterial endocarditis? No Yes

Do you have an artificial joint? No Yes, Joint(s) and date(s) of surgery _____

Have you ever bleeding problems after dental work or surgery? No Yes

Do you have a tendency to bleed easily? No Yes

Do you take coumadin? No Yes, Date and value of last INR _____

Have you had skin cancer before? No Yes

If yes, location(s) and date (year): _____

Female patients: Are you pregnant? No Yes, Due date: _____

Are you lactating? No Yes

Please fill out this form completely and bring to your surgery appointment.

Check all that apply regarding your health:

General Health

Diabetes
Liver disease
Kidney disease
High/low Thyroid
Arthritis
Weight loss
Low back pain
Dizziness
Weakness

Cardiovascular

High blood pressure
Low blood pressure
Heart failure
Heart attack
Heart surgery
Angina
Heart valve disease
Mitral valve prolapse
Heart murmur
Irregular heart rhythm
Rheumatic fever
Peripheral vascular disease

Infectious

HIV
Hepatitis A
Hepatitis B
Hepatitis C
Tuberculosis

Hematologic

Enlarged lymph nodes
Bleeding disorder
Anemia
History of blood clot

Ophthalmologic

Glaucoma
Blindness

Neurologic

Stroke
Dementia
Paralyzed nerves
Muscle weakness
Seizures

Psychiatric disease

Depression
Severe anxiety
Bipolar disorder
Schizophrenia

Respiratory

Shortness of breath
Asthma
Emphysema
Bronchitis

Check all that apply:

Glasses

Hearing aid

Dentures

Cane

Walker

Wheelchair

Stretcher

Oxygen

Dialysis

Oxygen

SOCIAL AND FAMILY HISTORY

Occupation: _____

Alcohol use: None Social/occasional drinking only Heavy drinking

Recreational drug use: No Yes

Smoking: No Former Yes, Packs/day _____

Do you live alone? No Yes Do you have someone who can help you with bandages? No Yes

Do you have someone who can accompany you on the day of surgery? No Yes

Any family history of skin cancer? None Melanoma Basal cell Squamous Cell Other _____

SKIN CANCER RISK FACTORS

Do you have a history of excessive sun exposure in childhood or as an adult? No Yes

Do you tend to burn or freckle easily? No Yes

Do you use sunblock routinely? No Yes

Do you have an outdoor occupation or hobbies? No Yes _____

Have you had X-ray treatment for a skin disease in the past? No Yes

Have you had an organ transplantation? No Yes

CONTACT INFORMATION

Pharmacy name and phone number _____

Which phone number(s) are best to reach you?

Home _____

May we leave a message at this number? No Yes

Cell _____

May we leave a message at this number? No Yes

Work _____

May we leave a message at this number? No Yes

Patient signature

For office use only: I have reviewed the patient's health information with the patient and documented any changes:

Asst: _____ MD: _____ Date: _____ Asst: _____ MD: _____ Date: _____

Asst: _____ MD: _____ Date: _____ Asst: _____ MD: _____ Date: _____

Asst: _____ MD: _____ Date: _____ Asst: _____ MD: _____ Date: _____

Asst: _____ MD: _____ Date: _____ Asst: _____ MD: _____ Date: _____

Please fill out this form completely and bring to your surgery appointment.

Asst: _____ MD: _____ Date: _____ Asst: _____ MD: _____ Date: _____