CASCADE Eye & Skin Centers, P.C.

ACMS American College of Mohs Surgery

Dermatologic Surgery Pre-Operative Health Questionnaire

Please complete this health information form prior to your appointment

Patient Name: _____ Date: _____

Referring Physician: _____ Age: _____ Sex: M / F

Reason for visit:

Where is the location of the lesion being treated? _____

How long have you had this problem? _____

How does this problem bother you? (Symptoms): _____

Besides the biopsy, have you received any treatment for this lesion? _____

Is your problem: Worsening? Stable? Improving? Explain: _____

Allergies: □ None □ Medications: _____

□ Adhesive □ Local Anesthetic: _____

□ Latex □ Other: _____

Women: Are you pregnant? □ Yes □ No Are you nursing? □ Yes □ No

Do you require antibiotics prior to dental procedures or surgery? □ Yes □ No

Do you have or have you ever had any of the following conditions?

	Yes	No	Comments
Heart Problems			
High Blood Pressure			
Pacemaker/Defibrillator			
Artificial Heart Valve			
Joint Replacement			
Stroke			
Lung Problems			
Kidney Disease			
Bleeding Problems			
Liver Disease / Hepatitis			
HIV / AIDS			
Diabetes			
Back / Neck Pain			
Memory Problems			
Cancer (other than skin cancer)			
Seizures			
Immunosuppression			
MRSA infection			
Reaction to local anesthetic			
Healing problems			
Fainting or dizzy spells			

Are you on or have you taken in the past month:

	Yes	No	Comments
Anticoagulants such as Coumadin (Warfarin), Pradaxa, Xarelto, or Eliquis			If you are taking Coumadin, what is your most recent INR? _____
Aspirin			
Plavix			
NSAIDS (ie. Ibuprofen)			

Please list all your medications / drugs you are currently taking (including non-prescription medications).

Medication	Dosage	How often?

Family History:

Do you have a family history of skin cancer? □ Yes □ No

If yes, who? □ Mother □ Father □ Brother □ Sister

If yes, what type? □ Basal cell carcinoma □ Squamous cell carcinoma □ Melanoma □ Unknown

Social History:

What is your occupation (current/former?) _____

Tobacco Use	Sunscreen Use	Sunburn History	Tanning	Alcohol	Marital Status
□ Never smoked □ Former smoker □ Light tobacco smoker □ Heavy tobacco smoker □ Current every day smoker □ Current some day smoker	□ No □ Yes □ Recent user □ Lifetime user	□ None □ Few □ Numerous □ Blistering	□ Never □ Infrequently □ Frequently	□ None □ Drinks socially □ Drinks frequently	□ Single □ Married □ Separated □ Divorced □ Widowed

Immunization History:

Have you had a flu shot within the last year? □ Yes □ No Date: _____

Have you had a pneumonia shot within the last year? □ Yes □ No Date: _____

Pharmacy Information:

Pharmacy Name:_____ Phone Number: _____

Pharmacy Address (or cross streets): _____

_____ _____

Patient/Guardian Signature Reviewer