Dermatology Professionals Mohs Surgery Questionnaire

PLEASE complete **BOTH sides** of this form and bring it to your appointment, along with a list of your medications

MEDICAL HISTORY (circle all that apply)

General: Frequent fevers   Excessive fatigue   Weight loss   Weight gain   Appetite loss

Heart Disease: High blood pressure   Angina   Heart attack   Disease of heart valves   Heart failure   Irregular heartbeats / murmur
Bypass or open heart surgery   Angioplasty +/-stents   **Pacemaker**   **Defibrillator**   other____________________

- ❖ **Do you have a history of artificial heart valves?** ***NO YES***   Type ____________________

Neurological: Seizures   Stroke   TIA   Frequent headaches   other____________________

Psychiatric: Anxiety   Depression   Frequent fainting spells   other____________________

Muscular/Skeletal: Rheumatoid arthritis   Osteoarthritis   other____________________

- ❖ **Any joint replacement?** ***NO YES***   If yes: when and which joints? ____________________

Pulmonary: Asthma   Emphysema   Shortness of breath   other____________________

Hematological: Bleeding problems   easily bruise   Anemia   other____________________

Have you ever seen a blood doctor (hematologist)? NO YES   *Have you ever had a low platelet count? NO YES*
Have you ever had a problem with your red blood cells or platelets? NO YES   *Have you ever had a transfusion? NO YES*

Cancers: Breast   Lung   Leukemia/Lymphoma   Prostate   Colon   other____________________
Date / Stage of cancer: ____________________

Infectious Disease: **HIV**   Tuberculosis   other____________________
Have you ever had a **Wound infection:** **MRSA**   Staph   other____________________

Liver Disease: Hepatitis B   Hepatitis C   Liver disease   Cirrhosis   other____________________

Genitourinary: Kidney disease   Dialysis   Transplant   BPH (benign prostatic hyperplasia)   other____________________

Gastrointestinal: Frequent GI upset   Ulcers   Reflux   Irritable bowel   other____________________

Endocrine: Hyperthyroid   Hypothyroid   **Diabetes, Type 1 / Type 2**   other____________________

Eyes: Glaucoma   Eye pain   Loss of vision   Tearing   other____________________

Ears: Decreased hearing   Hearing aids   other____________________

Nose: Draining allergies   Restricted nasal breathing   Surgery   other____________________

- ❖ **Do you take antibiotics before dental work?** ***NO YES***   Name & dose: ____________________

List any past surgeries and dates of surgery ____________________

____

Who is able to drive you home after surgery? (Name & ph number) ____________________

Name, phone and town of your primary care doctor ____________________

Pharmacy Name ____________________   Phone # ____________________

Pharmacy Address ____________________

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Name ______________________________ DOB: ______________

Occupation ______________________________

Where is the area of concern? ______________________ How long has it been there? ______________

Was this area treated in the past? *NO YES* If Yes, how was area treated? ______________

What are your symptoms? Bleeding itching scabbing pain other ______________

Have you ever had radiation on the skin? *NO YES* (explain) ______________

Have you had skin cancers before? *NO YES* Type: Basal Cell / Squamous Cell / **Melanoma**
Where? ______________ When? ______________

Have other family members had skin cancers? *NO YES* Type: Basal Cell / Squamous Cell / **Melanoma** / type unknown
Who? ______________

Do you take any of the following: Coumadin / warfarin Plavix Pradaxa Eliquis Effient Prednisone Aggrenox Aspirin Aleve Ibuprofen / Advil / Motrin Vitamin E Fish Oil

List ALL medications, dosages and frequency are you currently taking (including over the counter)

Medication Ex: Zyrtec 10mg	Dose 1 pill	How many times a day once per day	Medication	Dose	How many times a day

Medication allergies: ______________

Type of reaction: Anaphylaxis Angioedema GI upset / Nausea / Diarrhea Dizziness Fatigue Hives / Rash / Weal Swelling Liver toxicity Shortness of breath Other: ______________

Are you allergic to **latex** products? *NO YES* Are you allergic to **iodine**? *NO YES*

Have you had a Flu Vaccine? *NO YES* When: ________ Have you had a Pneumonia vaccine? *NO YES* When: ________

Do you have a history of psoriasis or psoriatic arthritis? *NO YES* If yes, have you been tested for TB? *NO YES* When ________ Result ________

Do you have an Advance Care Plan (someone who can make medical decision on your behalf if you are unable to speak for yourself)? *NO YES*

Name of your healthcare proxy or surrogate: ______________

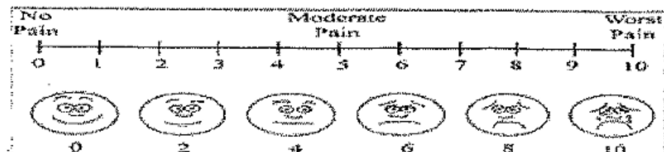
Do you smoke (cigarettes, cigars, pipe, etc.)? **NO Former smoker?** Year started ______ Year quit ______ **Check if you NEVER smoked** ____

IF YES How much? 2-3 per month 2-3 per week less than 1 pack per day 1 or more packs per day

Alcohol: NONE Less than 1 drink per week Less than 1 per day 1-2 per day 3+ per day

Number of times in the past year you have had more than 4 drinks in one day ______________

Are you having pain today? *NO YES* please circle level of pain:



Location of pain: ______________

FEMALES – circle any that apply: **currently pregnant nursing planning pregnancy**

OVER