Greater Washington Dermatology

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PREOPERATIVE HEALTH INFORMATION FORM

Patient Name: _____ **Date:** _____

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

Primary care provider:_____

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

How long has this problem been present? _____

Have you had a biopsy of this site? ☐ No ☐ Yes

Other than a biopsy, have you previously had treatment at this site? ☐ No ☐ Yes If yes, what type of treatment?

_____ _____

Mohs surgery patients: I have read the instructions in the Mohs Surgery Patient Handbook ☐ No ☐ Yes
If not, please read these instructions.

Past and Active Medical Problems: _____

_____

_____

_____

Previous major surgeries and dates (year): _____

_____

Medications (Please list **ALL** PRESCRIPTION and NON-PRESCRIPTION medications that you take including aspirin, over-the-counter pills, vitamins and herbal remedies.) _____

_____

_____

_____

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

_____

Have you had any problems with local anesthesia or epinephrine?	☐ No	☐ Yes
If yes, what was the reaction?_____		
Are you allergic to latex?	☐ No	☐ Yes
Have you had difficulty with wound healing, 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 routine dental work or surgery?	☐ No	☐ Yes
Do you have an artificial heart valve?	☐ No	☐ Yes
Have you had bacterial endocarditis (infection of a heart valve)?	☐ No	☐ Yes
Do you have an artificial joint?	☐ No	☐ Yes
If yes, joint(s) and date(s) of surgery_____		
Have you ever had bleeding problems after dental work or surgery?	☐ No	☐ Yes
Do you have a tendency to bleed or bruise easily?	☐ No	☐ Yes
Do you take Coumadin?	☐ No	☐ Yes
Female patients: Are you pregnant?	☐ No	☐ Yes, Due date:_____
Are you lactating?	☐ No	☐ Yes
Date of last menstrual period: _____		
Skin cancer patients: Have you had skin cancer before?	☐ No	☐ Yes

OVER →

Check all that apply regarding your health:

General Health
- ☐ Diabetes
- ☐ Liver disease
- ☐ Kidney disease
- ☐ High/low Thyroid
- ☐ Arthritis/Joint pain
- ☐ Weight loss
- ☐ Low back pain
- ☐ Fatigue

Respiratory
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis

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
- ☐ Fevers/chills

Neurologic
- ☐ Stroke
- ☐ Dementia
- ☐ Paralyzed nerves
- ☐ Muscle weakness
- ☐ Seizures
- ☐ Dizziness
- ☐ Weakness

Hematologic
- ☐ Enlarged lymph nodes
- ☐ Bleeding disorder
- ☐ Anemia
- ☐ History of blood clot

Ophthalmologic
- ☐ Glaucoma
- ☐ Blindness
- ☐ Blurred vision
- ☐ Decreased vision

Psychiatric disease
- ☐ Depression
- ☐ Severe anxiety
- ☐ Bipolar disorder
- ☐ Schizophrenia

Check all that apply: ☐ Glasses ☐ Hearing aid ☐ Dentures ☐ Cane ☐ Walker ☐ Wheelchair ☐ Stretcher ☐ Oxygen ☐ Dialysis

SOCIAL AND FAMILY HISTORY

Occupation: _____

Alcohol use: ☐ None ☐ Social/occasional drinking only ☐ Heavy drinking

Recreational drug use: ☐ No ☐ Yes

Smoking: ☐ No ☐ Yes, Packs/day _____

Do you live alone? ☐ No ☐ Yes

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

Do you have someone who can help you with changing bandages? ☐ No ☐ Yes,

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

FOR SKIN CANCER PATIENTS:

Have you had an organ transplantation? ☐ No ☐ Yes

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

Do you have a history of blistering sunburns 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 _____

CONTACT INFORMATION

Pharmacy name, street, and city: _____

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

☐ Home_____May we leave a message at this number regarding your healthcare? ☐ No ☐ Yes

☐ Cell_____ May we leave a message at this number regarding your healthcare? ☐ No ☐ Yes

☐ Work_____ May we leave a message at this number regarding your healthcare? ☐ No ☐ Yes

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