Dermatology Professionals Mohs Surgery Questionnaire

PLEASE complete this form and bring it to your appointment.

Your name _____ DOB: _____

Where is the area of concern?_____

How long has it been there?_____

What are your symptoms? bleeding_____ itching_____ scabbing_____ pain_____ other_____

Was this area treated in the past? Yes / No If Yes, how was area treated?_____

Have you ever had radiation on the skin? Yes / No (explain)_____

Rate your lifetime sun exposure (not just recent years) Significant____ Moderate____ Minimal____

Have you had skin cancers before? Yes____ No____ Where?_____

Have other family members had skin cancers? Yes____ No____ Who? _____

Do you take: Aspirin_____ Coumadin_____ Plavix_____ Vitamin E_____ Fish Oil_____ Prednisone____

Or any of the following agents? (Advil, Motrin, Aleve, or Ibuprofen, etc...) _____

What other medications are you currently taking (including over the counter)?

_____ _____ _____ _____

_____ _____ _____ _____

Are you ALLERGIC to any medications Yes____ No____

If yes, please list medication allergies: _____

Are you allergic to latex products? Yes____ No____

Do you have a history of artificial heart valves? Yes___ No___ Any joint replacement? Yes___ No___

If yes: when and what body part? _____

Do you take antibiotics before you have dental work? Yes___ No___

General: (check all that apply) 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 heart beats____Pacemaker____Defibrillator____ Heart murmur____

Bypass or open heart surgery_____ Angioplasty +/-stents_____ other_____

Psychiatric: Anxiety____ Depression____ Frequent fainting spells____ other_____

Muscular/Skeletal: Rheumatoid arthritis____ Osteoarthritis____ other_____

Pulmonary: Asthma____ Emphysema____ Shortness of breath____ other_____

Hematological: Bleeding problems____ easily bruise____ Anemia____ other_____

Have you ever seen a blood doctor (hematologist)? Yes____No____

Have you ever had a problem with your red blood cells or platelets? Yes____No____

Have you ever had a low platelet count? Yes____No____

Have you ever had a transfusion? Yes____No____

Cancers: Breast___ Lung___ Leukemia/Lymphoma___ Prostate___ Colon___ other_____

Infectious Disease: HIV____ Tuberculosis____ other_____

Wound infections: MRSA _____ Staph _____ other_____

Liver Disease: Hepatitis B___ Hepatitis C___ Liver disease___ Cirrhosis____ other_____

Genitourinary: Kidney disease___ Dialysis___ Transplant___ BPH___ other_____

Gastrointestinal: Frequent GI upset___Ulcers___Reflux___Irritable bowel____ other_____

Neurological: Seizures____ Stroke_____ TIA_____ Frequent headaches____ other_____

Endocrine: Hyperthyroid____ Hypothyroid____ Diabetes ____ other_____

Eyes: Glaucoma____ Eye pain____ Loss of vision____ Tearing____ other_____

Ears: Decreased hearing____ Hearing aides____ other_____

Nose: Draining allergies____ Restricted nasal breathing____ Surgery____ other_____

List any past surgeries? _____

Do you currently moke? Yes____No____.....How much? _____Pack/s per day

Former smoker? Yes ____ No ____ .....Check if never a smoker _____

Alcohol consumption: daily___ weekends___ social occasions___ rarely___ never____

Who is able to drive you home after surgery? _____ No one_____

Occupation_____

Name & town of your primary care doctor_____

N. Jellinek S. Sweeney J.Robert L. Rainone J. O'Brien J. Wilson Date: _____