Dermatology & Cosmetic Surgery Center, PC

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Pre-Operative Assessment

Please complete this health questionnaire as accurately as possible to provide additive information about your past and present medical and surgical history. **Bring this completed form with you on the day of your surgery.** A nurse prior to your procedure will review it with you.

Patient Name:____ Date:_____________

Height: _____ Weight: _____

Do you have a Living Will or Advance Directives? Yes or No

ALLERGIES:____

LATEX OR TAPE ALLERGIES:____

Do you develop keloid (thick scars) after surgery?____

Have you had any problems with local anesthesia? (if yes explain) ____________________________________

Do you have a pacemaker or defibrillator? (if yes which side?) ______________________________________

Women only: Are you pregnant? **YES NO**
If YES, How far along? ____________

Medical and Surgical History:
Have you ever had any of the following conditions? ***Please circle all conditions that apply.***

Neuro/Muscular
Stroke
Headache/Blurred Vision
Seizures
Brain Surgery
Mental Disorders
Brain Tumor
Multiple Sclerosis
Muscular Dystrophy
Other:____________

Respiratory
Breathing Problems
Lung Disease
Asthma
Emphysema
COPD
Lung Transplant
Collapsed Lung
Smoker
Chronic Cough
Other:_______

Cardiovascular
Heart Attack
Heart Problems
High Blood Pressure
Irregular Heart Rate
Open Heart Surgery
Heart Transplant
Heart Valve Replacement
**Pacemaker
**Internal Defibrillator (AICD)
Poor Circulation

Gastrointestinal
Gallbladder Disease
Liver Disease
Stomach Ulcers
Irritable Bowel Syndrome
Other:____________

Genital/Urinary/Gyn
Hyperactive Bladder
Enlarged Prostate
Prostate Cancer
Uterine/Ovarian Cancer
Breast Cancer
Other:_____________

Orthopedic/Muscular
Osteoporosis
Broken Bones
Artificial Joint Replacement
Arthritis
Back Problems
Physical Disabilities
Limited Motion:___________

Infectious Disease
Hepatitis
AIDS
HIV
TB (Tuberculosis)
MRSA
Other:___________

Kidney/Endocrine Disease
Renal Failure
Dialysis
Kidney Stones
Thyroid Disease
Kidney Transplant
Diabetes

Blood/Skin Disease
Anemia
Bleeding Problems
Leukemia
Skin Cancer
Other:____________

Are you currently being treated with:

____ Steroid Therapy _____ Immunosuppression Therapy ____Chemotherapy

Previous Surgeries:

Surgery	Site	Year

Medications

Please list below all the medications you take: Include prescriptions and over the counter medications (including vitamins and herbal supplements).

Name	Dose	Times

Pharmacy/Location:____

Pharmacy Phone Number: ____

Do you smoke?	Yes	No	Were you a previous smoker?	Yes	No
Do you drink alcohol?	Yes	No			
Do you wear dentures?	Yes	No	Do you wear contact lenses?	Yes	No

Patient Signature:____

Reviewed by:____________________RN **Date**:_______________________________