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
Do you drink alcohol? ☐ Yes ☐ No
Do you wear dentures? ☐ Yes ☐ No

Were you a previous smoker? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Received pre-operative written instructions.

Patient Signature:_____

Reviewed by:_____RN **Date**:_____