

Preoperative Evaluation For Dermatologic Surgery

Date: _____

Name: _____ Date of Birth _____ Sex: M/F

Day Time Phone Number: _____

SSN: _____

Location of Skin Lesion: _____

Has this lesion been treated before? Y/N

Have you had any previous skin cancers? Y/N

Family History of skin cancer: _____

Have you ever been exposed to radiation? Y/N

Do you smoke? Y/N If so, how much: _____

Have you taken aspirin in the past 10 days? Y/N Dose: _____

Do you take Coumadin? Y/N Plavix? Y/N

List all prescription and over-the-counter medications: _____

List all medication allergies : _____

Do you have any artificial heart valves, artificial joints, or heart murmurs? Y/N

If yes, specify: _____

Do you have a pacemaker or defibrillator? Y/N specify: _____

Do you have diabetes: Y/N

Do you have heart problems? Y/N specify: _____

Do you have any breathing problems? Y/N specify: _____

Have you had any organs transplanted? Y/N specify: _____

Do you have any other medical problems? _____

Primary Care Physician: _____ PCP phone #: _____