MOHS PREOPERATIVE QUESTIONNAIRE

Patient Name:_____ DOB:_____

Past Medical History

	Yes	No	Year		Yes	No	Year		Yes	No	Year
Anxiety				Irregular heart rhythm				Organ Transplant			
Depression				Atrial Fibrillation				Blood Clots			
Diabetes				Chest Pain				Pacemaker			
Liver disease				Heart Attack				Defibrillator			
Hepatitis				High blood pressure				Heart Valve Replacement			
Fainting				Bypass Surgery				Stroke			

Current Weight _____ Current Height _____

Do you have artificial joints, valves? Yes No
Do you take antibiotics before surgical procedures? Yes No

Are you immunosuppressed? Yes No
Have you had or have you been exposed to HIV (AIDS)? Yes No
Have you ever been diagnosed with Chronic Lymphocytic Leukemia? Yes No When_____

Do you drink alcohol? Yes No, If Yes, drinks per day and what type_____
Do you use IV drugs? Yes No If Yes, what?_____How much?_____
Do you currently smoke? Yes No Have you tried to quit? Yes No

Have you ever had dental anesthesia (Novocain)? Yes No Any bad reaction? Yes No

Do you bleed easily? Yes No
Do you take any OTC medications that thin your blood (Aspirin, Aleve, Ibuprofen) or supplements that thin your blood (fish oil, garlic, vitamin E, Ginko Biloba)? Yes No
Do you take any medications that thin your blood (Coumadin, Plavix, Xarelto, Eliquis or another prescribed blood thinner)? Yes No

Has anyone in your family had skin cancer? Yes No Relation?_____
Do you have a family history of other cancers? Yes No Relation?_____

Medications:

Name of medication/supplement	Dose	Frequency

Are you allergic to any medications: Yes No If yes, please list below:

(Women) Are you pregnant or nursing? Yes No Due Date:_____

What is your occupation?_____ What are your hobbies?_____