PLEASE COMPLETE FRONT AND BACK AND RETURN TO OFFICE

ROCHESTER SKIN CANCER AND SURGERY CENTER
Dermatologic Surgery Preoperative Information Sheet

Name: _____ **Age**:_____ □ **M** □ **F** **Height** _____ **Weight** ____

Occupation_____

Previous Skin Cancer: □ Yes □ No Previous Mohs Surgery: □ Yes □ No
Family History of Skin Cancer: □ Yes □ No Is pregnancy possible? □ Yes □ No

Have you had a fall with injury in last year: □ Yes □ No
Are you up to date with routine vaccinations: (Flu, Pneumonia, Shingles, Tdap) □ Yes □ No

Past Medical History:
Please check "Yes" or "No" to the following, as it pertains to you:

Heart disease / Valve replacement / Murmur	□ Yes	□ No
Mitral Valve Prolapsed (M.V.P.)	□ Yes	□ No
Lung disease (Asthma, Emphysema, COPD)	□ Yes	□ No
Liver disease	□ Yes	□ No
Neurological disease/Dementia/Parkinson's	□ Yes	□ No
Cancer (other than skin)	□ Yes	□ No
Infectious disease	□ Yes	□ No
Hepatitis B or C or HIV	□ Yes	□ No
Diabetes	□ Yes	□ No
Hypertension (High Blood Pressure)	□ Yes	□ No
Hypertension controlled	□ Yes	□ No
Bleeding Tendencies	□ Yes	□ No
Healing problems/scars (keloids)	□ Yes	□ No
Cold sore/Herpes	□ Yes	□ No
Pacemaker, Defibrillator, Stent	□ Yes	□ No
Urinary Incontinence	□ Yes	□ No
Artificial implant/prosthesis/joint replacement	□ Yes	□ No
Do you need antibiotics for prophylaxis prior to procedures?	□ Yes	□ No

Please list any history of serious illness or operations: _____
_____

Other medical problems we need to be aware of:
_____

Do you take Aspirin on a regular basis □ Yes □ No Date of last dose _____
Do you take a blood thinner: □ Yes □ No Date of last dose _____

Please list any allergies you have to medications or tape and what type of reaction you have:
_____

_____

Do you use tobacco: □ Yes □ No If yes how many times a day _____
Do you use alcohol: □ Yes □ No If yes, how many drinks per week _____

All of the above is stated to the best of my knowledge.

Patient Signature:_____ **Date:** _____

Rochester Skin Cancer and Surgery Center

Patient Medication List

DATE: _____

MEDICATIONS MUST BE LISTED ON THIS SHEET. WE **CAN NOT** ACCEPT A COPY

Patient Name: _____ DOB:_____

Pharmacy name and phone number:

_____

On the chart below, please list **ALL** medications and over the counter medications or supplements you are currently taking. Be sure to include the name, dosage, frequency and route of administration (oral, injection, etc.) for each medication.

NAME OF MEDICATION	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION (Oral, Injection, Ophthalmic, Inhalation, etc)

*If you need more space, please attach a separate form

Patient Signature:_____ Date: _____