

Dermatology & Cosmetic Surgery Center, PC

100 North Wren Drive • Pittsburgh, PA 15243 • Phone (412) 429-2570 • Fax (412) 429-2572
Office Hours: Monday - Friday 7AM – 12PM and 1PM – 4PM

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 back 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:

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

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

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

Infectious Disease

Hepatitis
AIDS
HIV
TB (Tuberculosis)
Other: _____

Kidney/Endocrine Disease

Renal Failure
Dialysis
Kidney Stones
Thyroid Disease
Diabetes

Blood/Skin Disease

Anemia
Bleeding Problems
Leukemia
Skin Cancer
Other: _____

Are you currently being treated with:

____ Steroid Therapy ____ Immunosuppression Therapy

____ Chemotherapy

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Previous Surgeries:

<u>Surgery</u>	<u>Site</u>	<u>Year</u>
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Medications

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

<u>Name</u>	<u>Dose</u>	<u>Times</u>
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Pharmacy/Location: _____

Pharmacy Phone Number: _____

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

Patient Signature: _____

Reviewed by: _____ RN **Date:** _____