

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?) _____

Have you fallen in the past 12 months? YES NO If YES, DATE: _____

Do you have difficulty walking or balancing, or use a cane/walker? YES NO

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
- ☐ Anxiety
- ☐ Depression
- ☐ Other 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
- ☐ Cardiac Stents
- ☐ Heart Valve Replacement
- ☐ **Pacemaker
- ☐ **Internal Defibrillator (AICD)
- ☐ Poor Circulation

Infectious Disease

- ☐ Hepatitis
- ☐ AIDS
- ☐ HIV
- ☐ TB (Tuberculosis)
- ☐ MRSA
- ☐ Other: _____

Gastrointestinal

- ☐ Gallbladder Disease
- ☐ Liver Disease
- ☐ Stomach Ulcers
- ☐ Irritable Bowel Syndrome
- ☐ Reflux/GERD
- ☐ 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: _____

Kidney/Endocrine Disease

- ☐ Renal Failure
- ☐ Dialysis
- ☐ Kidney Stones
- ☐ Thyroid Disease
- ☐ Kidney Transplant
- ☐ Diabetes - Type I / Type II

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

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Pharmacy/Location: _____

Pharmacy Phone Number: _____

Do you smoke? Yes or No

Do you drink alcohol? Yes or No

Do you wear dentures? Yes or No

Were you a previous smoker? Yes or No

Do you wear contact lenses? Yes or No

Received pre-operative written instructions. ☐

Patient Signature: _____

Reviewed by: _____ RN Date: _____