PITTSBURGHSKIN
DERMATOLOGY | MOHS SURGERY

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MOHS SURGERY QUESTIONNAIRE

Please complete this form and bring to your appointment.

Patient Name _____ Date of Birth _____
(Last) *(First)* *(Middle)*

Occupation _____ Date _____

Name of Primary Care Physician _____

Address _____

Where is the area of concern? _____ How long has the condition been present? _____

Was this area treated in the past? ☐ Yes ☐ No If yes, how was the area treated? _____

Have you ever had radiation on the skin? ☐ Yes ☐ No If yes, please explain _____

Have you had skin cancer before? ☐ Yes ☐ No If yes, where? _____

Does your family have a history of skin cancer? ☐ Yes ☐ No If yes, please list members _____

_____

Do you take the following: ☐ Aspirin ☐ Ibuprofen ☐ Coumadin ☐ Plavix ☐ Vitamin E ☐ Fish Oil ☐ Advil ☐ Motrin

☐ Prednisone ☐ Aleve ☐ Other _____

What other medications are your currently taking? (Include name and dosage of prescription and over-the-counter medications)
Attach additional list if needed.

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list medication allergies _____

_____

Are you allergic to late products? ☐ Yes ☐ No

Do you have a history of artificial heart valves? ☐ Yes ☐ No Any joint replacement? ☐ Yes ☐ No

If yes, please note when and what body part _____

Do you take antibiotics before you have dental work? ☐ Yes ☐ No

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Medical Conditions: (check all that apply)

General: ☐ Frequent Fevers ☐ Excessive Fatigue ☐ Weight Loss ☐ Weight Gain ☐ Appetite Loss

Heart Disease: ☐ High Blood Pressure ☐ Angina ☐ Heart Attack ☐ Disease of Heart Valves ☐ Heart Failure
☐ Irregular Heart Beats ☐ Pacemaker ☐ Defibrillator ☐ Bypass or Open Heart Surgery
☐ Heart Murmur ☐ Angioplasty +/- Stents ☐ Other _____

Neurological: ☐ Seizures ☐ Stroke ☐ TIA ☐ Frequent Headaches ☐ Other _____

Psychiatric: ☐ Anxiety ☐ Depression ☐ Frequent Fainting Spells ☐ Other _____

Muscular/Skeletal: ☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Other _____

Pulmonary: ☐ Asthma ☐ Emphysema ☐ Shortness of Breath ☐ Other _____

Hematological: ☐ Bleeding Problems ☐ Easily Bruise ☐ Anemia ☐ Other _____

Have you ever seen a blood doctor (hematologist)? ☐ Yes ☐ No

Have you ever had a problem with your red blood cells or platelets? ☐ Yes ☐ No

Have you ever had a low platelet count? ☐ Yes ☐ No

Have you ever had a transfusion? ☐ Yes ☐ No

Cancers: ☐ Breast ☐ Lung ☐ Leukemia/Lymphoma ☐ Prostate ☐ Colon ☐ Other _____

Infectious Disease: ☐ HIV ☐ Tuberculosis ☐ Other _____

Wound Infections: ☐ MRSA ☐ Staph ☐ Other _____

Liver Disease: ☐ Hepatitis B ☐ Hepatitis C ☐ Liver Disease ☐ Cirrhosis ☐ Colon ☐ Other _____

Genitourinary: ☐ Kidney Disease ☐ Dialysis ☐ Transplant ☐ BPH ☐ Other _____

Gastrointestinal: ☐ Frequent GI Upset ☐ Ulcers ☐ Reflux ☐ Irritable Bowel ☐ Other _____

Endocrine: ☐ Hyperthyroid ☐ Hypothyroid ☐ Diabetes ☐ Other _____

Eyes: ☐ Glaucoma ☐ Eye Pain ☐ Loss of Vision ☐ Tearing ☐ Other _____

Ears: ☐ Decreased Hearing ☐ Hearing Aides ☐ Other _____

Nose: ☐ Draining Allergies ☐ Restricted Nasal Breathing ☐ Surgery ☐ Other _____

Please list any past surgeries: _____

Do you smoke? ☐ Yes ☐ No How much? _____ pack/s per day

Alcohol consumption? ☐ Yes ☐ No ☐ Daily ☐ Weekends ☐ Social Occasions ☐ Rarely ☐ Never

Who is able to drive you home after surgery? _____ ☐ No one