McFarland Clinic

Dermatologic Surgery Preoperative Information Sheet

Name:____ Age:__________

Occupation:____

Do you make your own medical decisions? ☐yes ☐no If no, who assists?__________________

Skin Cancer History

Yes	No	
☐	☐	Previous skin cancer
☐	☐	Previous melanoma skin cancer
☐	☐	Family history of skin cancer

Past Medical History

Yes	No	
☐	☐	High Blood Pressure
		If yes, is it medication controlled?______________________________
☐	☐	Heart disease / Heart Valve Replacement / Murmur
☐	☐	Pacemaker
☐	☐	Defibrillator
☐	☐	Lung disease/COPD/Asthma
☐	☐	Stroke/Seizure/Dementia
☐	☐	Cancer (other than skin cancer): ______________________________
☐	☐	Infectious diseases such as Hepatitis B or C or HIV
☐	☐	Diabetes
☐	☐	Organ Transplant
☐	☐	Kidney Disease
☐	☐	Bleeding tendencies
☐	☐	Healing problems/keloids
☐	☐	Do you need antibiotics before dental work or procedures?
☐	☐	Do you have artificial joints?
☐	☐	Do you have an implanted device (cochlear implant, spinal nerve stimulator, spinal pain pump or cosmetic implant)?

Other medical problems: ____

____

____

____

Medications

If taking a blood thinner medication, please circle your medication:

Aspirin
Ibuprofen
Coumadin/Warfarin
Plavix/Clopidogrel
Xarelto/Rivaroxaban
Pradaxa/Dabigatran
Eliquis/Apixaban
Savaysa/Edoxaban
Arixtra/Fondaparinux
Lovenox/Heparin

List other medications: ______________________________
____
____
____

List of allergies: ______________________________
____
____
____

Habits

Yes	No	Occassionally	
☐	☐	☐	Do you use tobacco?
☐	☐	☐	Do you consume alcohol?

Women Only

Yes	No	
☐	☐	Are you pregnant?
☐	☐	Are you breastfeeding?

Fall Prevention Questionnaire

1. Do you use any of the following devices to help you get around?

   Cane   Walker   Wheelchair   Crutches
   Braces   Other ______________   None

2. Have you fallen 2 or more times in the past year?

   Yes
   No

3. Have you been hurt in a fall in the last year?

   Yes
   No

If you answered yes to 2 or more, please bring someone to assist with walking during your visit.