The New Women's College Hospital

MOHS Pre-Operative Health Questionnaire

In order that we may better understand your entire picture, please fill in this form about the state of your health at the present time.

1. Allergies to medications? Yes ρ No ρ Allergies to Latex? Yes ρ No ρ

If yes, please explain: ____

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2. Do you have or have you ever had any of the following conditions?

	YES	NO	COMMENTS
Heart problems			
Pacemaker			
Heart valve problem			
Joint replacement			
Artificial body part			
Diabetes			
Kidney trouble			
High blood pressure			
Cancer (other than skin cancer)			
Epilepsy			
Jaundice			
Bleeding problem			
Healing problem			
Radiation therapy			
Lung problems			

3. Please list all medications/drugs you are currently taking (this includes all non-prescription medications such as Aspirin, Ibuprofen and vitamins).

MEDICATION	DOSAGE	HOW OFTEN?

4. Are you on or have you taken in the past month:

	YES	NO	COMMENTS
Anticoagulants			
Aspirin			
Anti-inflammatory Drugs			
Vitamin E			

5. Have you or any of your family members ever had a reaction to local anesthetics? Yes ρ No ρ

If yes, please explain: ______________________________

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6. Do you have problems with your:

	YES	NO	COMMENTS
Hearing			
Vision			
Walking			
Speech			

7. Do you now or have you in the past year smoked? Yes ρ No ρ

If yes: Number of years ______________ Number of Cigarettes per day ______________

8. Alcohol consumption: Yes ρ No ρ Number of glasses per day/week __________

9. Have you had any surgery or hospitalization? Yes ρ No ρ

If yes, please explain: ______________________________

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10. Do you take antibiotics for dental work? Yes ρ No ρ

If yes, please explain: ______________________________

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Nurse Signature ______________________ Patient Signature ______________________

Date ______________________________