

**KELLEY PAGLIAI REDBORD, M.D.**

**PREOPERATIVE HEALTH INFORMATION FORM**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Gender: M F Age \_\_\_\_\_ Date of birth: \_\_\_\_\_ Marital status S M D W

Primary care provider: \_\_\_\_\_

Location(s) of problem(s) for which you are being seen \_\_\_\_\_

How long has this problem been present? \_\_\_\_\_

Have you had a biopsy of this site?  No  Yes

Other than a biopsy, have you previously had treatment at this site?  No  Yes If yes, what type of treatment?

**Mohs surgery patients:** I have read the instructions in the Mohs Surgery Patient Handbook  No  Yes  
If not, please read these instructions.

**Past and Active Medical Problems:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Previous major surgeries and dates (year):** \_\_\_\_\_

\_\_\_\_\_

**Medications** (Please list ALL PRESCRIPTION and NON-PRESCRIPTION medications that you take including aspirin, over-the-counter pills, vitamins and herbal remedies.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies to Medications**  None  Yes (List medication and how you react): \_\_\_\_\_

\_\_\_\_\_

Have you had any problems with local anesthesia or epinephrine?  No  Yes

If yes, what was the reaction? \_\_\_\_\_

Are you allergic to latex?  No  Yes

Have you had difficulty with wound healing, abnormal scarring or keloids?  No  Yes

Do you have a pacemaker?  No  Yes

Do you have an internal defibrillator?  No  Yes

Have you been advised to take antibiotics before routine dental work or surgery?  No  Yes

Do you have an artificial heart valve?  No  Yes

Have you had bacterial endocarditis (infection of a heart valve)?  No  Yes

Do you have an artificial joint?  No  Yes

If yes, joint(s) and date(s) of surgery \_\_\_\_\_

Have you ever had bleeding problems after dental work or surgery?  No  Yes

Do you have a tendency to bleed or bruise easily?  No  Yes

Do you take Coumadin?  No  Yes

**Female patients:** Are you pregnant?  No  Yes, Due date: \_\_\_\_\_

Are you lactating?  No  Yes

Date of last menstrual period: \_\_\_\_\_

**Skin cancer patients:** Have you had skin cancer before?  No  Yes

**OVER →**

**Check all that apply regarding your health:**

General Health

- Diabetes
- Liver disease
- Kidney disease
- High/low Thyroid
- Arthritis/Joint pain
- Weight loss
- Low back pain
- Fatigue

Respiratory

- Shortness of breath
- Wheezing
- Asthma
- Emphysema
- Bronchitis

Cardiovascular

- High blood pressure
- Low blood pressure
- Heart failure
- Heart attack
- Heart surgery
- Angina
- Heart valve disease
- Mitral valve prolapse
- Heart murmur
- Irregular heart rhythm
- Rheumatic fever
- Peripheral vascular disease

Infectious

- HIV
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Tuberculosis
- Fevers/chills

Neurologic

- Stroke
- Dementia
- Paralyzed nerves
- Muscle weakness
- Seizures
- Dizziness
- Weakness

Hematologic

- Enlarged lymph nodes
- Bleeding disorder
- Anemia
- History of blood clot

Ophthalmologic

- Glaucoma
- Blindness
- Blurred vision
- Decreased vision

Psychiatric disease

- Depression
- Severe anxiety
- Bipolar disorder
- Schizophrenia

**Check all that apply:**

- Glasses
- Cane
- Stretcher
- Hearing aid
- Walker
- Oxygen
- Dentures
- Wheelchair
- Dialysis

**SOCIAL AND FAMILY HISTORY**

Occupation: \_\_\_\_\_

Alcohol use:  None  Social/occasional drinking only  Heavy drinking

Recreational drug use:  No  Yes

Smoking:  No  Yes, Packs/day \_\_\_\_\_

Do you live alone?  No  Yes

Do you have someone who can accompany you on the day of surgery?  No  Yes

Do you have someone who can help you with changing bandages?  No  Yes,

Any family history of skin cancer?  None  Melanoma  Basal cell  Squamous Cell  Other \_\_\_\_\_

**FOR SKIN CANCER PATIENTS:**

Have you had an organ transplantation?  No  Yes

Have you had X-ray treatment for a skin disease in the past?  No  Yes

Do you have a history of blistering sunburns in childhood or as an adult?  No  Yes

Do you tend to burn or freckle easily?  No  Yes

Do you use sunblock routinely?  No  Yes

Do you have an outdoor occupation or hobbies?  No  Yes \_\_\_\_\_

**CONTACT INFORMATION**

Pharmacy name, street, and city: \_\_\_\_\_

Which phone number(s) are best to reach you?

Home \_\_\_\_\_ May we leave a message at this number regarding your healthcare?  No  Yes

Cell \_\_\_\_\_ May we leave a message at this number regarding your healthcare?  No  Yes

Work \_\_\_\_\_ May we leave a message at this number regarding your healthcare?  No  Yes

**For office use only:** I have reviewed the patient's health information with the patient and documented any changes:

Asst: \_\_\_\_\_ MD: \_\_\_\_\_ Date: \_\_\_\_\_ Asst: \_\_\_\_\_ MD: \_\_\_\_\_ Date: \_\_\_\_\_

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Asst: \_\_\_\_\_ MD: \_\_\_\_\_ Date: \_\_\_\_\_ Asst: \_\_\_\_\_ MD: \_\_\_\_\_ Date: \_\_\_\_\_