MONTROSE DERMATOLOGY + Cosmetics

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www.MontroseDermatology.com

Patient Name:_____

Patient DOB:_____

Bridget Walker, MD
~ Mohs Micrographic Surgeon

MEDICAL QUESTIONNAIRE

Medications:

Are you allergic to any medications? **Yes / No**

If yes, list the medication(s) and your reaction:_____

_____

_____

Do you take warfarin (Coumadin or Jantoven)? **Yes / No**

If yes, what is your most recent INR:_____

Do you take any blood thinners or medications to prevent blood clots? **Yes / No**

(e.g. Eliquis/apixaban, Xarelto/rivaroxaban, Plavix/clopidogrel, or others)

If yes, which ones do you take:_____

When was your last dose:_____

Do you take aspirin, ibuprofen, naproxen, celecoxib, diclofenac, or other NSAID medications? **Yes / No**

If yes, which ones do you take:_____

When was your last dose:_____

Social History:

Are you employed? **Yes / No**

If yes, what is your occupation:_____

Do you perform any strenuous work? **Yes / No**

Do you smoke? **Yes / No**

If yes, for how many years:_____

How many cigarettes per day:_____

Do you drink alcohol? **Yes / No**

If yes, what is the amount and frequency:_____

Medical History:

Do you have a history of skin cancer? **Yes / No**

If yes, list type of skin cancer and location for each:_____

_____

_____

Have you ever had Mohs surgery? **Yes / No**

If yes, list year and location for each:_____

Have you had an organ transplant? **Yes / No**

If yes, which organ:_____

What year was your transplant:_____

What antirejection medications do you take:_____

OVER PLEASE →

MEDICAL QUESTIONNAIRE CONTINUED

Do you have a history of any of the following conditions or diseases?

Yes / No Hypertension (high blood pressure): If yes, explain:_____

Yes / No Diabetes: If yes, explain:_____

Yes / No Bleeding tendency: If yes, explain:_____

Yes / No Artificial joint: If yes, explain:_____

Yes / No Artificial heart valve: If yes, explain:_____

Yes / No Pacemaker: If yes, explain:_____

Yes / No Defibrillator: If yes, explain:_____

Yes / No Deep brain stimulator: If yes, explain:_____

Yes / No Cochlear implant: If yes, explain:_____

Yes / No Staph or MRSA infection: If yes, explain:_____

Yes / No HIV infection/exposure: If yes, explain:_____

Yes / No Hepatitis B or C infection/exposure: If yes, explain:_____

Yes / No CLL (chronic lymphocytic leukemia): If yes, explain:_____

Yes / No Lymphoma: If yes, explain:_____

Yes / No Heart attack: If yes, explain:_____

Yes / No Heart disease: If yes, explain:_____

Yes / No Irregular heartbeat: If yes, explain:_____

Yes / No Asthma: If yes, explain:_____

Yes / No COPD/emphysema: If yes, explain:_____

Yes / No Liver disease: If yes, explain:_____

Yes / No Kidney disease: If yes, explain:_____

Yes / No Stroke: If yes, explain:_____

Yes / No Seizure disorder: If yes, explain:_____

Yes / No Severe anxiety: If yes, explain:_____

Yes / No Depression: If yes, explain:_____

Additional Notes/Comments:_____

_____

_____

_____