Dermatology & Cosmetic Surgery Center, PC

100 North Wren Drive • Pittsburgh, PA 15243 • Phone (412) 429-2570 • Fax (412) 429-2572
Office Hours: Monday - Friday 7AM – 12PM and 1PM – 4PM

Pre-Operative Assessment

Please complete this health questionnaire as accurately as possible to provide additive information about your past and present medical and surgical history. **Bring this completed form back with you on the day of your surgery.** A nurse prior to your procedure will review it with you

Patient Name:_____ Date:_____

Height: _____ Weight: _____

Do you have a Living Will or Advance Directives? Yes or No

ALLERGIES:

_____

LATEX OR TAPE ALLERGIES:

_____

Have you had any problems with local anesthesia? (if yes explain) _____

Do you have a pacemaker or defibrillator? (if yes which side?) _____

Medical and Surgical History:
Have you ever had any of the following conditions? ***Please circle all conditions that apply.***

Neuro/Muscular
Stroke
Headache/Blurred Vision
Seizures
Brain Surgery
Mental Disorders
Brain Tumor
Multiple Sclerosis
Muscular Dystrophy
Other:_____

Respiratory
Breathing Problems
Lung Disease
Asthma
Emphysema
COPD
Lung Transplant
Collapsed Lung
Smoker
Chronic Cough
Other:_____

Cardiovascular
Heart Attack
Heart Problems
High Blood Pressure
Irregular Heart Rate
Open Heart Surgery
Heart Transplant
Heart Valve Replacement
**Pacemaker
**Internal Defibrillator (AICD)
Poor Circulation

Gastrointestinal
Gallbladder Disease
Liver Disease
Stomach Ulcers
Irritable Bowel Syndrome
Other:_____

Genital/Urinary/Gyn
Hyperactive Bladder
Enlarged Prostate
Prostate Cancer
Uterine/Ovarian Cancer
Breast Cancer
Other:_____

Orthopedic/Muscular
Osteoporosis
Broken Bones
Artificial Joint Replacement
Arthritis
Back Problems
Physical Disabilities

Infectious Disease
Hepatitis
AIDS
HIV
TB (Tuberculosis)
Other:_____

Kidney/Endocrine Disease
Renal Failure
Dialysis
Kidney Stones
Thyroid Disease
Diabetes

Blood/Skin Disease
Anemia
Bleeding Problems
Leukemia
Skin Cancer
Other:_____

Are you currently being treated with:
____ Steroid Therapy _____ Immunosupression Therapy ____Chemotherapy

Previous Surgeries:

Surgery	Site	Year

Medications

Please list below all the medications you take: Include prescriptions and over the counter medications (including vitamins and herbal supplements).

Name	Dose	Times

Do you smoke? Yes or No
Do you drink alcohol? Yes or No
Do you wear dentures? Yes or No

Were you a previous smoker? Yes or No
Do you wear contact lenses? Yes or No

Patient Signature:_____

Reviewed by:_____RN **Date:**_____