SOLANO DERMATOLOGY ASSOCIATES

MOHS PRE-OPERATIVE QUESTIONNAIRE

Today's Date: _____

Patient Name: _____ **Date of Birth:** _____

MOHS APPOINTMENT DATE: _____ TIME: _____

Please Note: To cancel or re-schedule your appointment, please contact Jennifer at least 24 hours prior to your appointment at 707-643-5785 ext. 300. If you DO NOT cancel or re-schedule your appointment at least 24 hours in advance and DO NOT show to your appointment, **you will be billed a $200 nonrefundable fee.**

LOCATION:

- ☐ FAIRFIELD – 480 Chadbourne Rd, Suite 201, Fairfield CA 94537, Ph 707-399-4500
- ☐ VACAVILLE – 600 Nut Tree Rd, Suite 260, Vacaville CA 95687, Ph 707-452-7222
- ☐ VALLEJO- 2290 Sacramento St. Vallejo, CA 94590, Ph 707-643-5785
- ☐ ST. HELENA- 1030 Main St. Suite 200, St. Helena, CA 94574, Ph 707-963-5450
- ☐ NAPA- 1700 Second St. Suite 220, Napa CA 94558, Ph 707-252-2931

Referring Provider: _____ **Primary Care Provider:** _____

Pharmacy Name: _____ Street: _____ City: _____ Number: _____

YES / NO **Are you ALLERGIC to any medications?** Please list: _____

Do you take Blood Thinners: YES / NO (If yes, please answer below)

If Yes, for what diagnosis? _____

YES / NO Aspirin: 81 mg once a day OR 325 mg once a day (circle one)

YES / NO Coumadin (warfarin) – INR: _____ Date (within the past month): _____

YES / NO Plavix (clopidogrel)

YES / NO Xarelto (rivaroxaban)

YES / NO Eliquis (apixaban)

YES / NO Pradaxa (dabigatran)

YES / NO Savaysa (edoxaban)

Cardiologist Contact Info:

Name: _____

Ph: _____

Other Medications you are currently taking (prescriptions, aspirin, vitamins, herbal supplements):

Medication	Dose (mg)	How often (#/day)

****Please note: complete and bring this questionnaire with you to your Mohs appointment, take a photo of the biopsy site with your cell phone and bring it with you as well. Do Not wear any foundation, eyebrow pencil, eye liner or mascara if site of concern involves these areas****

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YES / NO **Do you take antibiotics prior to dental work?**

YES / NO **Do you smoke?**

YES / NO **Do you have difficulty walking, or need assistance transferring?**

***If you are in a wheelchair or may need assistance transferring to a surgical table, please let your Mohs scheduler know <u>BEFORE</u> the date of your surgery.**

<u>History of</u>:	YES / NO	**Organ Transplantation**	<u>Organ Transplant Physician Contact Info:</u> Name: _____ Ph: _____
	YES / NO	**Lymphoma**	
	YES / NO	**Leukemia** (e.g. **Chronic Lymphocytic Leukemia**)	
	YES / NO	**HIV/AIDS**	
	YES / NO	**Hepatitis B or Hepatitis C**	Treatment Date: _____
	YES / NO	**Heart Valve Surgery**	Date: _____
	YES / NO	**Joint Replacement Surgery**	Date: _____
	YES / NO	**Pacemaker / Defibrillator**	
	YES / NO	**Other Implantable Electronic Device (cochlear implant, deep brain, spinal cord or nerve stimulators, gastric pacemaker, bone stimulator)**	
	YES / NO	**Diabetes**	
	YES / NO	**Peripheral Artery Disease – "blocked or hardened arteries" in the legs**	
	YES / NO	**Venous Stasis – "leaky veins" in the legs**	
	YES / NO	**Skin Infections**	
	YES / NO	**Bandage/Adhesive Sensitivity**	
	YES / NO	**Suture Sensitivity**	
	YES / NO	**Keloid Scars**	
	YES / NO	**Vasovagal Reactions – "fainting or feeling faint" with procedures**	

For questions before your Mohs appointment, please contact your Mohs scheduler

For **Dr. Geisse**, **Dr. Gebauer** and **Dr. Fu** contact **Jennifer Bengtson** at 707-643-5785 ext. 300

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