SOLANO DERMATOLOGY ASSOCIATES

SURGERY PRE-OPERATIVE QUESTIONNAIRE

Today's Date: _____

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

SURGERY APPOINTMENT DATE: _____ TIME: _____

Please Note: To cancel or re-schedule your appointment, please contact the corresponding office from the location list below. 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 $100 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) Cardiologist Contact Info:

YES / NO Eliquis (apixaban) Name: _____

YES / NO Pradaxa (dabigatran) Ph: _____

YES / NO Savaysa (edoxaban)

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

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

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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**