SOLANO DERMATOLOGY ASSOCIATES

# MOHS PRE-OPERATIVE QUESTIONNAIRE

**Solano Dermatology Associates** **Today's Date:** _____

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

**Your MOHS APPOINTMENT DATE:** _____ TIME: _____

**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- 807 St. Helena Hwy Suite 2, 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)

| | | |
|---|---|---|
| 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) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

****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** Organ Transplant Physician Contact Info:

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 **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**

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

For **Dr. Gebauer** contact **Christy Weld** at (707)643-5785 ext: 337

For **Dr. Geisse** contact **Nakeyia Washington** at (707) 643-5785 ext: 354

For **Dr. Fu** contact **Gal Barrientos** at (707) 399-4500 ext: 514

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