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Kuchnir Dermatology
& Dermatologic Surgery

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Phone 508-872-2220
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Patient information

PREOPERATIVE PREPARATIONS

- Plan for a full day (average 4-7 hours)
- Have someone drive you
- Pack a big lunch and snacks
- Dress comfortably and in layers
- Pack a book or a laptop (wireless available)
- Call with questions or concerns

PATIENT MEDICAL HISTORY

Date: _____

Who referred you? _____

Who is your primary care physician? _____

When did you first notice this problem? _____

Skin area(s) involved? _____

Has this area been treated before? ☐ Yes ☐ No

If yes, when and how? _____

Was this area ever affected by a burn, scar, or trauma? ☐ Yes ☐ No

Please check all that apply to your current skin problem

Change in: ☐ Size ☐ Color ☐ Elevation ☐ Other _____

Associated symptoms: ☐ Bleeding ☐ Numbness ☐ Pain ☐ Itching ☐ Infection ☐ Scabbing ☐ Other _____

Severity of symptoms: ☐ None ☐ Occasional ☐ Constant

MEDICATIONS

Please list all the medicines you are currently taking, including aspirin, eye and ear drops, inhalers or breathing medicines, herbals, vitamins and supplements.

Name/Dose # Times Per Day

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

ALLERGIES to medications: i.e. Novocaine, Lidocaine, or any antibiotics. ☐ Yes ☐ No

If there is an allergy, what is your allergic response?

Name Allergic Response

1. _____
2. _____
3. _____
4. _____

ALLERGIES to latex, adhesive tape, or Band-Aids? ☐ Yes ☐ No

Medical History

Do you have history of:
- ☐ Excessive diagnostic x-ray
- ☐ Medical light treatments
- ☐ Immunosuppression
- ☐ Arsenic exposure
- ☐ Sunlamp/tanning bed use
- ☐ Welding arc
- ☐ Radiation therapy

How many times? _____ Date(s) Treated_____

Have you ever had skin cancer? ☐ Yes ☐ No

If yes, when and where on your skin? _____

Have you ever had melanoma? ☐ Yes ☐ No

If yes, when and where on your skin? _____

Has any of your family members been diagnosed with skin cancer? ☐ Yes ☐ No

If yes, please list the type(s): _____

_____

_____

Has any of your family members been diagnosed with melanoma? ☐ Yes ☐ No

If yes, please list person/relationship to you: _____

Was the melanoma fatal? ☐ Yes ☐ No

Do you burn easily in the sun? ☐ Yes ☐ No

When in the direct sun for one hour or more, how often do you burn?

☐ Always ☐ Usually ☐ Sometimes ☐ Minimal ☐ Never

How well do you tan? ☐ Always ☐ Gradually ☐ Minimal ☐ Never

Have you ever had a blistering sunburn? ☐ Yes ☐ No

If yes, when? _____ How many times? _____

Did you have freckles? ☐ Yes ☐ No

Original hair color? _____ Color of eyes? _____

Did you have numerous moles as teenager or young adult? ☐ Yes ☐ No

Have you had abnormal moles removed surgically? ☐ Yes ☐ No

If yes, how many?_____

Do you have excessive recreational sun exposure? (i.e. golf, tennis, boating, gardening, sunbathing, fishing, mountains, beach) ☐ Yes ☐ No

If yes, number of years you performed outdoor recreation: _____

Outdoor hours per week: _____

Have you spent many days on a boat? How many? _____

Do you routinely use sunscreens, hats, sun protective clothing or avoid sun exposure to minimize further skin damage by the sun? ☐ Yes ☐ No

Are you currently or possibly pregnant? ☐ Yes ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

Have you ever had a wound infection or infection after surgery? ☐ Yes ☐ No

Do you have a history of a staph or MRSA infection? ☐ Yes ☐ No

If yes, What: _____ Where: _____ When: _____

Treatment: _____

Do you have an infection anywhere? ☐ Yes ☐ No

Have you been hospitalized recently? ☐ Yes ☐ No

If yes, when and why? _____

_____

Have you worked with pesticides, insecticides, industrial solvents? ☐ Yes ☐ No

If yes, was this on the job exposure? _____

Social History

What is your occupation? _____

Have you ever worked an outdoor occupation? ☐ Yes ☐ No

If yes, what type of outdoor work? _____

Number of years/months? _____ Outdoor hours per day _____

Did you serve in the armed forces? ☐ Yes ☐ No

If yes, how long? _____ Where? _____

Hours outdoor per week? _____

Do you live ☐ at home alone ☐ with spouse ☐ partner ☐ children ☐ pet

Do/did you smoke? ☐ Yes ☐ No ____packs per day ____number of years

Do you drink alcohol? ☐ Yes ☐ No ____drinks per day ____drinks per week

Do you abuse substances such as alcohol, recreational drugs or inhalants? ☐ Yes ☐ No

Does anyone in your home cause you to be afraid for your safety? ☐ Yes ☐ No

Do you use seatbelts? ☐ Yes ☐ No

Do you have any of the following *(please circle or fill in the blank)*

Skin problems (psoriasis, poor healing, abnormal scarring, inflamed skin) ☐ Yes ☐ No

If yes, please list: _____

Gastrointestinal problems (ulcers, hepatitis, jaundice, liver disease) ☐ Yes ☐No

If yes, please list: _____

History of cold sores/facial herpes ☐ Yes ☐ No

Neurologic problems (stroke, Alzheimer's, seizures, TIA) ☐ Yes ☐ No

If yes, please list: _____

Cochlear implants (surgically implanted hearing aid) ☐ Yes ☐ No

Cardiovascular problems (heart attack, abnormal heart beat, chest pain, high blood pressure, stent, heart failure, bypass, heart defect, pacemaker, heart murmur, valve replacement, rheumatic fever, implanted cardiac defibrillator) ☐ Yes ☐ No

If yes, please list: _____

Kidney disease ☐ Yes ☐ No

Infectious disease (hepatitis, TB) ☐ Yes ☐ No

History of organ transplantation ☐ Yes ☐ No

If yes, please list organ and dates of transplant surgery: _____

_____

Joint replacement, artificial heart valve or any other surgically implanted prostheses ☐ Yes ☐ No

Asthma/Chronic Lung Disease ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

If yes, how is it controlled (diet, oral medication, insulin injections)? _____

_____

History of excessive bleeding or bleeding after medical procedures ☐ Yes ☐ No

History of a blood clot in your legs or lungs ☐ Yes ☐ No

History of endocrine (hormonal) disease ☐ Yes ☐ No

If yes, please list: _____

Operation to unclog or bypass arteries ☐ Yes ☐ No

Do you take blood thinning medicine? ☐ Yes ☐ No

If yes, please list: _____

Have your blood thinner tests been erratic (too high or too low) in the past or have you been told to stop taking the blood thinner due to abnormal blood tests results? ☐ Yes ☐ No

Do you have glaucoma? ☐ Yes ☐ No

History of autoimmune disorders (rheumatoid arthritis, lupus) ☐ Yes ☐ No

If yes, please list: _____

_____

Any history of emotional problems? ☐ Yes ☐ No

Have you ever had cancer (other than skin cancer)? ☐ Yes ☐ No

If yes, please list type and date diagnosed and therapy: _____

_____

Has anyone in your family (siblings or parents) had cancer? ☐ Yes ☐ No

If yes, please list: _____

_____

Any other major medical problems (not discussed previously)? ☐ Yes ☐ No

If yes, please explain: _____

_____

All previous surgeries and dates: _____

_____

_____

Have you had difficulty with healing? ☐ Yes ☐ No

Do you have prominent scarring? ☐ Yes ☐ No

Have you had cosmetic surgery? ☐ Yes ☐ No

Do any diseases run in your family? ☐ Yes ☐ No

If so, which ones? _____

Do you require antibiotics before dental work or surgery? ☐ Yes ☐ No

Are you currently under care of a Visiting Nurse? ☐ Yes ☐ No

Name and phone number of Visiting Nurse: _____

Who can help with you with wound dressing changes? _____

Physician Signature: _____ Date: _____