ADVANCED Dermasurgery Associates

Dr. Saira Momin
Dr. William Posten
Sarah Snitker, PA-C
American College of Mohs Surgery
Fellowship trained * Board certified

Dermatologic & Mohs Surgery

Patient Health Information

Pt. Name: ____

Date of Birth: ____

Date: ____

PLEASE PRINT

LIST ANY PREVIOUS SURGERIES BELOW: DATE:

____ ________________________

____ ________________________

____ ________________________

PLEASE LIST ALL MEDICATIONS, DRUGS, AND VITAMINS YOU ARE TAKING AT THE PRESENT TIME:

MEDICATION & DOSAGE: **HOW OFTEN:**

____ ________________________

____ ________________________

____ ________________________

____ ________________________

HEIGHT: _________(in.) WEIGHT: _________(lbs)

BMI = Weight / (Height x Height) x 703. If the BMI ≥23, we recommend and/or refer you back to your Primary Care Provider for further evaluation.

DO YOU TAKE ASPIRIN OR MOTRIN? YES ________ NO ________

DO YOU SMOKE? YES ________ NO ________ IF YES, HOW MANY PACKS PER DAY ________

DO YOU HAVE ALLERGIC REACTION TO ANY MEDICATIONS? YES ________ NO ________

MEDICATION: **TYPE OF REACTION:**

____ ________________________

____ ________________________

CHECK EITHER THE YES BOX OR NO BOX TO ALL APPLICABLE PRESENT OR PAST CONDITIONS:

YES	NO		YES	NO	
		AIDS virus infection/HIV			Emphysema
		Aneurysm			Fever Blister/Herpes
		Asthma			Hepatitis
		Prolonged Bleeding or Bleeding Disorder			Heart Attack
		Chest Pains			Heart Murmur
		Melanoma Date:_______________			High Blood Pressure
		Basal or Squamous Cell Skin Cancer			Irregular Heart Beats
		Dates Treated:_________________			Keloids/Abnormal Scars
		_________________________			Lupus/Autoimmune Disease
		_________________________			Pregnancy
		Other Skin Cancers			Rheumatic Fever
		Other Cancers - non-skin			Seizures
		Diabetes			Other conditions: ___________________________

PAST SURGERIES:

YES	NO		YES	NO	
		Artificial Heart Valves			Prosthesis
		Artificial Joints			Transplant
		Bypass			Vascular
		Pacemaker			

For office use only:

	A	B	C
Preop Size			
Photo Num			
Initial			

 Signature: ______________________________ **Date:** ________________ **Time:** _____________**am pm**