WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

76 Grenville Street, Toronto, ON M5S 1B2

Mohs Micrographic Surgery Skin Centre
Patient Health Questionaire

PATIENT IDENTIFICATION

Date: _____/___/____
YYYY/MM/DD

Please review your information above, and write any corrections on the lines provided.

Name: _____ Date of Birth: _____/___/___
YYYY/MM/DD

Address: _____

Home Telephone: _____ Cell: _____

Health Care Number: _____ Version Code: _____

Emergency contact: _____ Relationship to patient: _____

Telephone: (H) _____ (B) _____

Family Doctor: _____ Fax No: _____

1. Do you have or have you ever had any of the following conditions?

	Yes	No	
Known allergies to medications			
Known allergies to Latex / Band-Aids / Medical products			
Other known allergies			
Reaction to local anesthetic			
Bleeding or Healing problems			
Pacemaker / Heart valve problem			
Artificial body part or joint			Date of surgery _____/___/___ YYYY/MM/DD
Organ transplant			
Diabetes			
High blood pressure			
Cancer (other than skin cancer)			
Previous radiation therapy			Body area:
Epilepsy / seizures			
Jaundice / liver problems			
Lung or breathing problems			
Any other health problem			
Prosthesis/Hearing Aid			

CONTINUED ON BACK

WCHI
WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

76 Grenville Street, Toronto, ON M5S 1B2

Mohs Micrographic Surgery Skin Centre
Patient Health Questionaire

PATIENT IDENTIFICATION

2. List all medications/drugs/vitamins you are currently taking **(including non-prescription medications** such as Aspirin, Ibuprofen). It is not necessary to provide the dosages.

3. Smoking: ☐ Never ☐ Current ☐ Ex Year quit: _____

4.Other relevant information you wish to mention:

_____

_____

Patient Signature: _____ Date: _____/___/____
YYYY/MM/DD

OFFICE USE ONLY

Date of Mohs Surgery: _____/___/____
YYYY/MM/DD

Mohs Surgeon: _____

Date and Time of Repair: _____/___/____ Time: _____h
YYYY/MM/DD

Repair performed by: _____

Reviewed by Mohs Nurse on Date: _____/___/____
YYYY/MM/DD

Print Name:_____ Signature: _____Designation: _____

Please return this questionnaire by FAX to 416 323-6306 as soon as possible. Alternatively, you can mail it back in the envelope provided.