

76 Grenville Street, Toronto, ON M5S 1B2

## Mohs Micrographic Surgery Skin Centre Patient Health Questionaire

Patient Health Questionaire			PATIENT IDENTIFICATION	
Date: / / DD / MM / YYYY				
Please review your information ab	ove,	and	write any corrections on the lines provided.	
Name:			Date of Birth: / /	
Address:			DD / MM / YYYY	
Home Telephone:			Cell:	
			Version Code:	
			Relationship to patient:	
Telephone: (H)			(B)	
			Fax No:	
Do you have or have you ever had	any o	of the		
	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 / / DD / MM / YYYY	
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				



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<ol><li>List all medications/drugs/vitamin medications such as Aspirin, Ibupr</li></ol>	ns you are currently taking (cofen). It is not necessary to	including non-prescription oprovide the dosages.		
3. Smoking:   Never   Contact of the				
		air		
Patient Signature:	Date:	DD / MM / YYYY		
OFFICE USE ONLY				
Date of Mohs Surgery: / DD / MM	/ / <b>YYYY</b>			
Mohs Surgeon:		=		
Date and Time of Repair:/ / Time:h				
Repair performed by:		_		
Reviewed by Mohs Nurse on Da	ate: / / DD / MM / YYYY			
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.