Peninsula Dermatologic Surgery

Name (First and Last): ____
Date of Birth: ____

Patient Information

	YES	NO
Have you had a previous reaction to lidocaine or epinephrine (numbing medicine)?	☐	☐
Are you allergic to any medications, soaps, or shellfish? If yes, please list.	☐	☐

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	YES	NO
Are you taking a blood thinner (Aspirin, Plavix, Warfarin, Eliquis, Xarelto, etc.)? Please specify.	☐	☐

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Medical Questionnaire

Please check yes or no:	YES	NO		YES	NO
Do you have any of the following? Please circle all that apply: • Pacemaker/Defibrillator • Cochlear Implant • Deep Brain Stimulator • Spinal Cord Stimulator	☐	☐	Do you require antibiotics before surgical/dental procedures? If yes, is it for one of the following? Please circle all that apply: • Artificial heart valve(s) • Artificial joint(s) • History of endocarditis • Other: ____________________	☐	☐
HIV/AIDS	☐	☐	Keloids/Abnormal Scars	☐	☐
Hepatitis B or C	☐	☐	Organ Transplant	☐	☐
Diabetes	☐	☐	Leukemia/Lymphoma	☐	☐
Prolonged Bleeding or Bleeding Disorder	☐	☐	Immunocompromised for any other reason? (Please specify.) ________________________	☐	☐
Currently Smoking/Using Tobacco	☐	☐	Currently pregnant? If so, how many weeks?________________________	☐	☐
Do you wear a CPAP while you sleep for sleep apnea?	☐	☐	Current Pharmacy Name & Address:		

Please provide us with a list of your current prescription medications, over-the-counter medications, vitamins, and mineral/herbal supplements.

If needed, please use the back of this page for additional medications.