MOHS SURGERY OF MORRIS, P.A.
Subhadra Shah, M.D.

Patient Name:
Date of Birth:

Medical History	**YES**	**NO**
Previous Skin Cancer	____	____
Family History of Melanoma	____	____
Surgery (last 10 yrs) – list type + date		
Problems healing	____	____
Hepatitis [ ] A [ ] B [ ] C	____	____
Cancer:	____	____
HIV	____	____
Hypertension	____	____
Heart Disease: [ ] CAD [ ] CHF [ ] MVP [ ] Angina [ ] A Fib [ ] PVD [ ] Stent [ ] Prosthetic Valve	____	____
Vascular disease: [ ] Stroke [ ] Carotid Stenosis [ ] Other	____	____
Diabetes: Type [ ] I [ ] II	____	____
Seizure Disorder / Epilepsy	____	____
History of fainting	____	____
Kidney Disease	____	____
Pregnancy / possibility of	____	____
Respiratory / Lung Disease	____	____
Prosthetic joint (when?)	____	____
Use: Tobacco Alcohol Other	____	____

Occupation:

Activities:

General Health (subjective?) _____
Date

Medications (including OTC)	**Date**	**Initial**
Allergies:		

This section is for office use only

Anticoagulants: [ ] ASA [ ] Coumadin [ ] Other

Dose: _____

Date stopped: _____Per: _____, M.D.

Prophylaxis needed? [ ] Yes [ ] No

Antibiotic: _____

Reason: _____

Taken at what time: _____

MAY USE: reason:

Lidocaine [ ] Yes [ ] No _____

Epinephrine [ ] Yes [ ] No _____

PACEMAKER

DEFIBRILLATOR

Reviewed by: _____ Date: _____