University Hospital
University of Missouri Health Care
One Hospital Drive
Columbia, MO 65212
573/882-4141

Patient Health Inquiry Form for Cutaneous Surgery

Name: ______________________ Date of Birth: ____________

Medical Record Number: ______________________

Please indicate if you have any of the following:

Past Medical History:	No	Yes	Describe/Comment
Bleeding Disorders:	☐	☐	______
Organ Transplant:	☐	☐	______
Cancer (Solid Tumors):	☐	☐	______
Lymphoma/Leukemia:	☐	☐	______
Heart/Heart Valve Problems:	☐	☐	______
Joint Replacement:	☐	☐	______
Diabetes:	☐	☐	______
Liver Problems:	☐	☐	______
Pacemaker/Defibrillator:	☐	☐	______
Immunosuppression:	☐	☐	______
Previous Skin Cancers:	☐	☐	______
High Blood Pressure:	☐	☐	______
HIV/AIDS	☐	☐	______

Are you allergic or suffer from adverse reactions to any of the following medications?

Allergies:	No	Yes
Lidocaine:	☐	☐
Epinephrine:	☐	☐
Penicillin:	☐	☐
Cephalexin/Keflex:	☐	☐

List all medications that you are allergic to: ______________________

____

Medications:	No	Yes	
Are you on coumadin/warfarin?	☐	☐	If so, your most recent INR? ________ Date ________
Are you on Aspirin?	☐	☐	Dose ________ Last taken when? ________

Please list all your medications and doses: ______________________

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Do you need to take antibiotics prior to surgery or dental procedures? ☐ **No** ☐ **Yes**

Do you smoke cigarettes or chew tobacco? ☐ **No** ☐ **Yes** **If so, how much?** ____________

Do you drink alcohol? ☐ **No** ☐ **Yes** **If so, how much per week?** ____________

Please do not write below this line

☐ Patient health form reviewed with patient/family on day of surgery. Date: ____________

______________________ ______________________