

Patient Name: _____ **Date:** _____ **MRN:** _____
(For Office Use Only)

Where on the body are you having Mohs Surgery? _____

What type of cancer are you treating that requires Mohs Surgery?

- | | |
|--|--|
| <input type="checkbox"/> Basal Cell Carcinoma Basosquamous | <input type="checkbox"/> Merkel Cell Carcinoma |
| <input type="checkbox"/> Cell Carcinoma Dermatofibroma | <input type="checkbox"/> Microcystic Adnexal Carcinoma |
| <input type="checkbox"/> Sarcoma Protuberans Desmoplastic | <input type="checkbox"/> Squamous Cell Carcinoma |
| <input type="checkbox"/> Trichoepithelioma Lentigo Maligna | <input type="checkbox"/> Squamous Cell Carcinoma in Situ |
| <input type="checkbox"/> Melanoma | <input type="checkbox"/> Does not apply |
| <input type="checkbox"/> Other: _____ | |

What best describes your skin cancer? (Please check all that apply)

- | | |
|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Asymmetric | <input type="checkbox"/> Oozing |
| <input type="checkbox"/> Asymptomatic | <input type="checkbox"/> Scaly |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Spreading |
| <input type="checkbox"/> Draining | <input type="checkbox"/> Tender |
| <input type="checkbox"/> Excised | <input type="checkbox"/> Treated |
| <input type="checkbox"/> Growing | <input type="checkbox"/> None |
| <input type="checkbox"/> Not Healing | |
| <input type="checkbox"/> Other: _____ | |

What symptoms are associated with your skin cancer? (Please check all that apply)

- Burning
 Itching
 Stinging
 Does not apply
 Other: _____

Who is your referring Dermatologist? (Name) _____

Address: _____

Phone: _____ Fax: _____

Has this cancer been biopsied before? Yes No

How long have you had this skin cancer? _____

Check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> a current Infection | <input type="checkbox"/> Organ Transplant recipient |
| <input type="checkbox"/> a Defibrillator | <input type="checkbox"/> Premedicating prior to Surgeries |
| <input type="checkbox"/> a Pacemaker | <input type="checkbox"/> Prior Mohs Surgery done by us |
| <input type="checkbox"/> an Artificial Heart Valve | <input type="checkbox"/> Prior Mohs Surgery done elsewhere |
| <input type="checkbox"/> an Artificial Joint within the past 2 years | <input type="checkbox"/> Prior Mohs Surgery done to the area by us |
| <input type="checkbox"/> Anticoagulation Medication | <input type="checkbox"/> Prior Mohs Surgery done to the area done elsewhere |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Prior Treatment to the area by Cryotherapy |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Prior Treatment to the area by Electrodesiccation and Curettage |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Prior Treatment to the area by Excision |
| <input type="checkbox"/> Cardiac Valve Disease | <input type="checkbox"/> Prior Treatment to the area by Mohs |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Prior Treatment to the area by XRAY therapy |
| <input type="checkbox"/> Dysplastic Nevi | <input type="checkbox"/> Prior XRAY therapy for a previous skin cancer |
| <input type="checkbox"/> Family History of Melanoma | <input type="checkbox"/> Resides at Nursing Home |
| <input type="checkbox"/> Family History of Non-melanoma Skin Cancer | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Hepatitis C HIV | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Immunosuppressed | <input type="checkbox"/> Uses a Walker |
| <input type="checkbox"/> Lidocaine Allergy | <input type="checkbox"/> Uses a Wheelchair |
| <input type="checkbox"/> Lives Alone | <input type="checkbox"/> Does not apply |
| <input type="checkbox"/> Melanoma | |
| <input type="checkbox"/> Other: _____ | |