Northeast Dermatology Associates. 51 Webb Place Suite 240, Dover, N.H. 03820. (603) 343-4806

PRE- SURGICAL INSTRUCTIONS FOR MOHS SURGERY

Regarding your medications please read the following and review the specific instructions with the surgical team prior to surgery.

1. If you take aspirin, Plavix, or any anti-platelet medication because of a history of coronary artery disease, heart attack, heart disease, stroke, TIA, or peripheral vascular disease, please continue this medication prior to surgery.
2. If you take aspirin simply to "stay healthy" without a history of any of the above or other diseases, you may be asked to stop it 10 days prior to surgery.
3. If you take nonprescription medications, then stop all nonprescription medications including Vitamin E, Omega 3 products such as fish oil and flaxseed oil and herbal medications 2 weeks prior to surgery.
4. If you take Coumadin (warfarin), Xarelto, Eliquis, or Pradaxa because of a history of atrial fibrillation, heart disease, stroke, TIA, or deep venous thrombosis (DVT), pulmonary embolus, or other internal disease, please continue this medication prior to surgery. If you are taking Coumadin, we would like to have a blood test showing a PT/INR value within the expected range within 5 days of surgery.
5. If you take aspirin plus Plavix, aspirin plus Coumadin, or aspirin plus an anticoagulant (i.e. Xarelto, Eliquis, Pradaxa), please discuss this specifically with the surgical team prior to surgery.
6. Please discontinue ibuprofen (Advil, Motrin), naproxen, and all non-steroidal anti-inflammatory drugs 5 days prior to surgery.
7. Continue all other prescription medications without change.
8. No alcohol consumption for 48 hours prior to your surgical procedure/s and 48 hours after surgery
9. If you smoke, please limit/avoid tobacco as much as possible prior to surgery. Please try to stop cigarette smoking 2 weeks prior to surgery and refrain from smoking for 4 weeks after.
10. If you have an artificial joint or heart valve or need to take antibiotics prior to surgery or dentist visits, please discuss this with the surgical team prior to surgery.
11. If you check your blood sugars at home, then check your blood sugars at least daily after surgery and call your primary care physician if unable to control blood sugar
12. Please eat breakfast and/or lunch on the day of surgery.
13. Your surgery will normally take between 3-4 hours at the office. Please bring a snack, reading material, or something else to help pass the time.
14. Please arrange to have someone drive you home after surgery if your site is near your eye or where your glasses sit.
15. It is recommended that you wear comfortable, loose-fitting clothing and avoid "pullover" clothes.
16. For women: please do not wear makeup to surgery if the lesion is on your face.

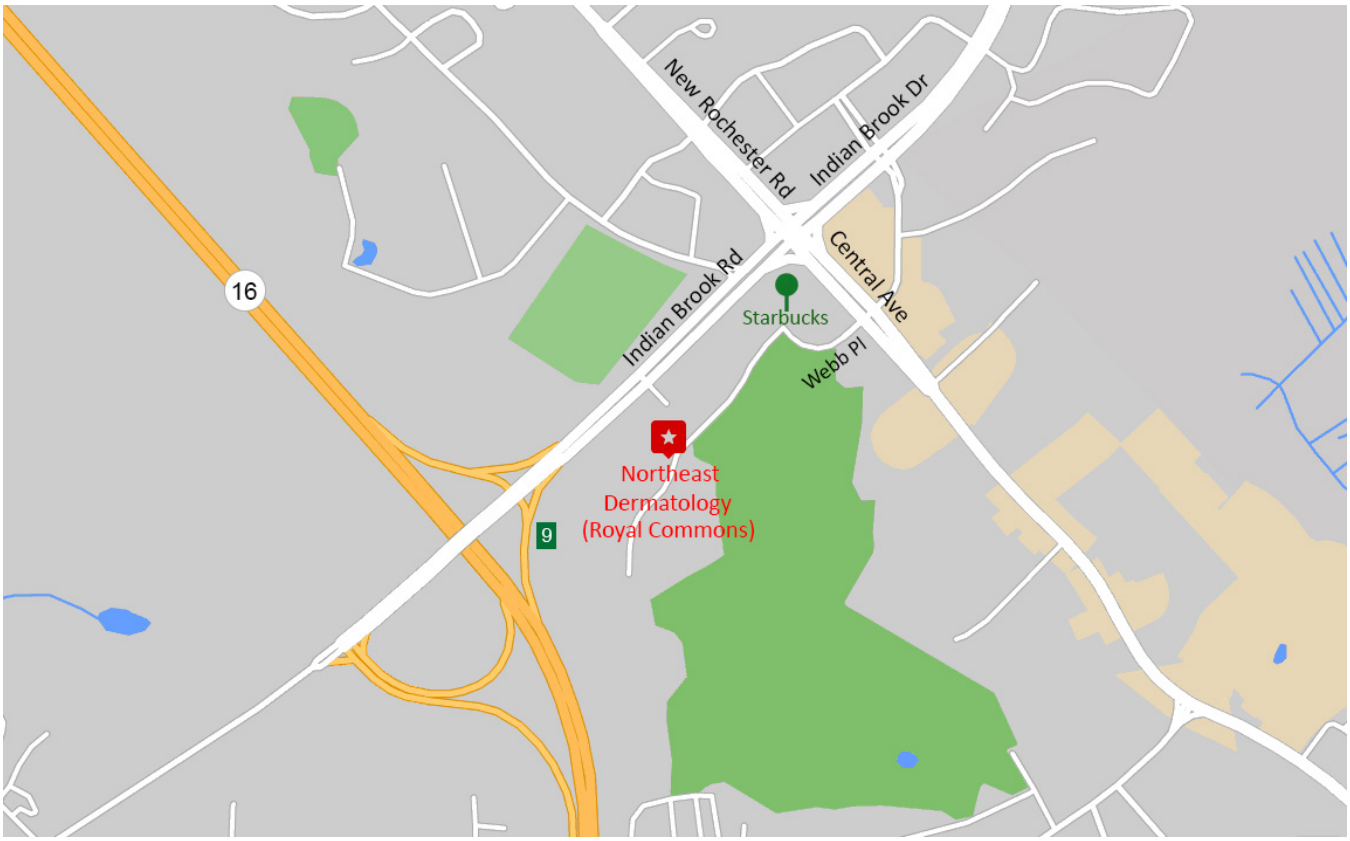
Call Northeast Dermatology at (603) 343-4806 to speak to our Billing Department regarding any insurance or payment issues.

DIRECTIONS

51 WEBB PLACE (ROYAL COMMONS BUILDING)
DOVER, NH

- Turn onto Webb Place (intersection of Webb Place and Central Ave)
- At stop sign across from Starbucks, turn left
- Continue following Webb Pl to 51 Webb Pl, brick building is named Royal Commons
- Take elevator to 2nd floor, Suite 240

If you have any issues finding the Dover office location on your day of surgery, please call 603-343-4806 ext 2000.



Mohs Surgery Questionnaire - Northeast Dermatology Associates. 51 Webb Place Suite 240, Dover, N.H. 03820. (603) 343-4806

PLEASE complete **BOTH sides** of this form and bring it to your appointment, along with a list of your medications

Name _____ DOB: _____

Occupation_____

Where is the area of concern? _____ How long has it been there? _____
Was this area treated in the past? *NO YES* If Yes, how was area treated?_____
What are your symptoms? Bleeding itching scabbing pain other_____

Have you ever had radiation on the skin? *NO YES* (explain)_____

Have you had skin cancers before? *NO YES* Type: Basal Cell / Squamous Cell / Melanoma
Where? _____ When? _____

Have other family members had skin cancers? *NO YES* Type: Basal Cell / Squamous Cell / Melanoma / type unknown
Who? _____

Do you take any of the following: Coumadin/Wafarin Plavix Pradaxa Eliquis Xarelto Effient Prednisone Aggrenox
Aspirin Aleve Ibuprofen / Advil / Motrin Vitamin E Fish Oil

List ALL medications, dosages and frequency are you currently taking (including over the counter)

Medication Ex: Zyrtec 10mg	Dose 1 pill	How many times a day once per day	Medication	Dose	How many times a day

Medication allergies: _____
Type of reaction: Anaphylaxis Angioedema GI upset / Nausea / Diarrhea Dizziness Fatigue Hives / Rash / Weal Swelling
Liver toxicity Shortness of breath Other:_____

Are you allergic to latex products? *NO YES* Are you allergic to iodine? *NO YES*

Have you had a Flu Vaccine? *NO YES* When:_____ Have you had a Pneumonia vaccine? *NO YES* When:_____

Do you have a history of psoriasis or psoriatic arthritis? *NO YES* If yes, have you been tested for TB? *NO YES* When _____ Result _____

Do you have an Advance Care Plan (someone who can make medical decision on your behalf if you are unable to speak for yourself)? *NO YES*

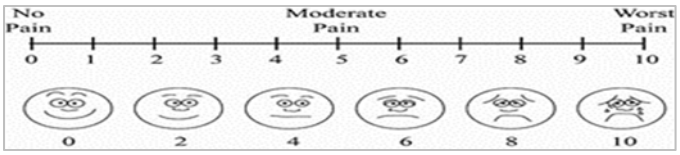
Name of your healthcare proxy or surrogate:_____

Do you smoke (cigarettes, cigars, pipe, etc.)? NO Former smoker? Year started_____ Year quit_____ Check if you NEVER smoked ____
IF YES How much? 2-3 per month 2-3 per week less than 1 pack per day 1 or more packs per day

Alcohol: NONE Less than 1 drink per week Less than 1 per day 1-2 per day 3+ per day
Number of times in the past year you have had more than 4 drinks in one day _____

Are you having pain today? *NO YES* please circle level of pain:

Location of pain: _____



FEMALES – circle any that apply: **currently pregnant** **nursing** **planning pregnancy**

OVER

Mohs Surgery Questionnaire - Northeast Dermatology Associates. 51 Webb Place Suite 240, Dover, N.H. 03820. (603) 343-4806

PLEASE complete **BOTH sides** of this form and bring it to your appointment, along with a list of your medications

Name _____ DOB: _____

MEDICAL HISTORY (circle all that apply)

General: Frequent fevers Excessive fatigue Weight loss Weight gain Appetite loss

Heart Disease: High blood pressure Angina Heart attack Disease of heart valves Heart failure Irregular heartbeats / murmur
Bypass or open heart surgery Angioplasty +/-stents Pacemaker Defibrillator other_____
❖ Do you have a history of artificial heart valves? *NO YES* Type _____

Neurological: Seizures Stroke TIA Frequent headaches other_____

Psychiatric: Anxiety Depression Frequent fainting spells other_____

Muscular/Skeletal: Rheumatoid arthritis Osteoarthritis other_____
❖ Any joint replacement? *NO YES* If yes: when and which joints? _____

Pulmonary: Asthma Emphysema Shortness of breath other_____

Hematological: Bleeding problems easily bruise Anemia other_____
Have you ever seen a blood doctor (hematologist)? NO YES *Have you ever had a low platelet count? NO YES*
Have you ever had a problem with your red blood cells or platelets? NO YES *Have you ever had a transfusion? NO YES*

Cancers: Breast Lung Leukemia/Lymphoma Prostate Colon other_____
Date / Stage of cancer: _____

Infectious Disease: HIV Tuberculosis other_____
Have you ever had a Wound infection: MRSA Staph other_____

Liver Disease: Hepatitis B Hepatitis C Liver disease Cirrhosis other_____

Genitourinary: Kidney disease Dialysis Transplant BPH (benign prostatic hyperplasia) other_____

Gastrointestinal: Frequent GI upset Ulcers Reflux Irritable bowel other_____

Endocrine: Hyperthyroid Hypothyroid Diabetes, Type 1 / Type 2 other_____

Eyes: Glaucoma Eye pain Loss of vision Tearing other_____

Ears: Decreased hearing Hearing aids other_____

Nose: Draining allergies Restricted nasal breathing Surgery other_____

❖ Do you take antibiotics before dental work? *NO YES* Name & dose: _____

List any past surgeries and dates of surgery _____

_____

Name, phone and town of your primary care doctor _____

If you are a new patient, or have not been to our practice in over 3 years, please complete the following:

Do you have:	Yes	No		Do you have:	Yes	No
Problems with bleeding				Fever or chills		
Problems with scarring (hypertrophic or keloid)				Hay fever		
Changing mole				Shortness of breath		
Cough				Thyroid problems		

Pharmacy Name _____ Phone # _____

Pharmacy Address _____