CENTER FOR SURGICAL DERMATOLOGY &
CENTER FOR SURGICAL DERMATOLGY AMBULATORY SURGERY CENTER

Patient Medical History

NAME: ______________________________ DATE: ______________

DATE OF BIRTH: ______________ SEX: ❐M ❐F REFERRED BY: ______________________

Reason for Today's visit: ____

PAST MEDICAL HISTORY:

ALLERGIES:
Are there medications or other items to which you have had an allergic reaction or unpleasant side effect? ❐ Yes ❐ No
If yes, please list these items below and describe the side effect:

1. ______________________________ 3. ______________________________

2. ______________________________ 4. ______________________________

MEDICATIONS: Please list any prescription and non-prescription medications including pain relievers you are currently taking. Please include medication name and dosage. If you are taking more medications than space provides, please continue on a separate sheet of paper.

Medication	Dosage	Frequency	Medication	Dosage	Frequency

CHRONIC DISEASES AND SURGERIES
Please list any chronic diseases, major illnesses and surgeries you have had:

1. ______________________________ 5. ______________________________

2. ______________________________ 6. ______________________________

3. ______________________________ 7. ______________________________

4. ______________________________ 8. ______________________________

Do you have: ❐ defibrillator ❐ artificial joints ❐ take coumadin? ❐ yes - date of last INR __________ ❐ no

PERSONAL/SOCIAL HISTORY

Do you wear: ❐ dentures ❐ glasses ❐ contact lenses ❐ hearing aids

Smoking: ❐ no ❐ former ❐ yes, packs per day: __________

Alcohol: ❐ no ❐ social/occasional drinking only ❐ daily, drinks per day: __________

Alcohol or drug problems/addictions: ❐ no ❐ yes. If yes, please describe: ______________________

Pharmacy Name: ______________________ **Phone #** ( ) ______________________

Pharmacy Street: ______________________ **City:** ______________ **Zip code:** __________

May we obtain a history of prescriptions directly from your pharmacy? ❐ Yes ❐ No

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Patient Medical History

PATIENT NAME: ________________________________ **DOB:** _________________________

PAST MEDICAL HISTORY/FAMILY HISTORY AND REVIEW OF SYSTEMS

Please check the boxes below if **you or anyone in your immediate family** has the following conditions:
(if other please note in box below)

Skin	**Self**	**Family**
Melanoma		
Basal/Squamous		
# of Cancers ______		
Pre-Cancer		
Abnormal Scarring		
Plastic Surgery		
Changing Moles		
Other:		
Neurological		
Stroke		
Seizures		
Other:		
Endocrine		
Diabetes		
Thyroid		
Kidney Disease		
Other:		
Infections		
Hepatitis		
HIV/AIDS		
Increased Risk for AIDS		
Tuberculosis (TB)		
Productive Cough		
Weight Loss		
Night Sweats		
Exposure		
Other:		

Hematologic/Lymphatic	**Self**	**Family**
Anemia		
Bleeding problems		
Enlarged Lymph Nodes		
Other:		
Respiratory		
Emphysema		
Shortness of Breath		
Other:		
Constitutional		
Unexplained Weight Loss		
Fever		
Other:		
Gastrointestinal		
Stomach Ulcer		
Colitis		
Liver Disease		
Other:		
Eyes/Ears/Nose/Throat		
Glaucoma		
Plastic Surgery		
Other:		

Cardiovascular	**Self**	**Family**
Angina (chest pain)		
Artificial Valve		
Irregular Heart Rhythm		
Pacemaker		
Hypertension		
Heart Attack		
AICD (Defibrillator)		
Other:		
Musculoskeletal		
Arthritis		
Artificial Joint		
Have you fallen in the past 30 days? Yes No		
Do you use a wheelchair or ambulatory aids? Yes No Type: __________________		
Psychiatric		
Depression		
Anxiety Attacks		
Personality Disorder		
Other:		
Cancer (Non-Skin)		
Please list:		

Patient Signature **Date**

Form reviewed and verified (please sign and date for each appointment):

CSD Employee Sign Here			**CSD ASC Employee Sign Here**	
Name (Signature)	Date	Physician Initials	Name (Signature)	Date
Name (Signature)	Date	Physician Initials	Name (Signature)	Date
Name (Signature)	Date	Physician Initials	Name (Signature)	Date
Name (Signature)	Date	Physician Initials	Name (Signature)	Date

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Patient Demographics

(Please print)

Patient's Name:________________________ Name I Preferred to be Called: __________

Home Address: ____

City: ________________________ State:__________ Zip:______________

Home Phone: ____________________ E-mail: ________________________

Cell Phone: ____________________ May we send you information via e-mail regarding cosmetic specials? ☐ Yes ☐ No

Work Phone: ____________________

Date of Birth: ____________________ Social Security #: __________________

Race: ☐ African American ☐ American Indian ☐ Asian ☐Caucasian ☐ Hispanic

Marital Status: ☐ Married ☐ Single ☐ Widow/Widower ☐ Divorced

Sex: ☐ Male ☐ Female

Employer: __________________________ Occupation: ________________

Employer Address: ____

City: ________________________ State: __________ Zip:______________

Spouse's Name if applicable:______________________ Date of Birth: __________

Emergency Contact: ____

Phone Number: __________________________ **Relationship:** ______________

How were you referred to our office?

☐ Physician
☐ RSVP Mailer ☐ Ad in Suburban News ☐ Friend ☐ Yellow Pages
☐ Skin Cancer Screening ☐ Family ☐ Self ☐ Other

Primary Care Physician:________________ Referring Physician:________________

Address: ______________________ Address: ______________________

City: __________State:______ Zip: ______ City: __________State: ______ Zip: ______

Phone Number: ____________________ Phone Number: ____________________

Patient Name: ______________________________ **Date of Birth:** ______________

Fiscally Responsible Party Information (If Other Than Patient)

Name: ______________________________

Home Address: ______________________________

City: ____________________ State:__________ Zip: ______________

Home Phone: ____________________ Home E-mail: ____________________

Insurance Information

Is a referral required for this appointment? ☐ Yes ☐ No

Primary Insurance: ______________________________

Policy #:____________________ Group #: ____________________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Parent

If subscriber other than patient, please complete the following information:

Subscriber Name: ______________________________

Home Address: ______________________________

City: ____________________ State: __________ Zip: ______________

Date of Birth: ____________________ Social Security# ____________________

Secondary Insurance (If Applicable)

Secondary Insurance: ______________________________

Policy #:____________________ Group#: ____________________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Parent

Subscriber Name (if other than patient): ______________________________

Date of Birth: ____________________ Social Security# ____________________

I certify that as the patient or responsible party I assign all insurance benefits to the Center for Surgical Dermatology (CSD) and/or Center for Surgical Dermatology Ambulatory Surgery Center (CSD ASC) and its physicians otherwise payable to me. I understand and agree that I am financially responsible for all charges whether or not paid by my insurance. My signature further authorizes CSD/CSD ASC to release information necessary to obtain payment of benefits.

____

Signature of Patient Date
(or Responsible Party & Relationship to Patient)

BRIAN P. BIERNAT, M.D.
PETER C. SELINE, M.D.
ANGELA S. CASEY, M.D.
RONALD J. SIEGLE, M.D., EMERITUS

LINDA S. RUPERT, M.D.
BRADLEY S. SODER, M.D.
DEEPA C. LINGAM, M.D.
NANDA CHANNAIAH, D.O
JAMES SAN FILIPPO, M.D.
DHWANI MEHTA, M.D.
AMI PATEL SHETH, MS, CNP
KELSIE HAMMOND, MS, CNP
CHRIS WEBBER, PA-C

MOHS MICROGRAPHIC SURGERY

What is Mohs surgery?

- A skin cancer removal technique that offers the highest cure rate. This technique allows the doctor to remove the least possible amount of healthy tissue while still removing all the cancer.
- This technique is usually used for skin cancers which:
  - are located in areas where a greater amount of healthy tissue needs to be preserved (ie. eyes, nose, ears, hairline, hands, etc).
  - have a high risk for recurrence or have recurred with previous treatment.
  - have borders that are not well defined and/or have other skin cancers in close proximity.
  - are large in size.
- A Mohs surgeon is specially trained in surgery, pathology, and reconstruction.

What can I expect the day of surgery?

- Please arrive 15 minutes early with **completed paperwork, photo ID, and insurance/Medicare cards.**
- The area will be numbed with local anesthesia. The visible tumor will be removed along with a layer of the surrounding tissue.
- The tissue will be processed in our lab which typically takes around one hour. You will wait in the waiting room during this time.
- Once the tissue is ready, the doctor will examine the tissue under the microscope.
- If cancer remains, another layer of tissue will be removed. This process will be repeated until the entire tumor is removed. The average number of tissue layers removed is 2 to 3.
- When the tumor is completely removed, the doctor will discuss with you the best options for closing the wound.
- Because it is unknown how many times the doctor will need to take tissue, it is impossible to predict how long your surgery will last. **It may only take several hours, but <u>be prepared to spend the entire day with us</u>.**
- **<u>We request that you do NOT schedule any other appointments for the day of surgery.</u>**
- Bring books, magazines, or another activity to help pass your time. We do have Wi-Fi available for your use.

Is there food available?

- **<u>We recommend you bring your lunch with you</u>**. We do have a refrigerator in which we can store cold items from your lunch. There are also vending machines available with beverages and limited snack items.
- We do have a Keurig coffee machine available.

<u>Diabetics, continue to take your medication. Follow your regular meal schedule by bringing snacks and your lunch.</u>

CONTINUED

Should I bring a driver?

- If the surgical site is anywhere near your eye, the final dressing may limit or occlude your vision.
- If you are feeling very anxious, we can give a medication to help calm your nerves called Valium; however, **in order to be given Valium a driver is required**.
- If you are unsure if you need a driver, it is always better to have one with you or have someone on standby if the need arises.

Are there any medications that would affect my surgery?

** **The morning of surgery, take all prescribed medications. Eat a regular breakfast and also bring any medications you normally take throughout the day.** **

- **Unless otherwise instructed by your prescribing physician, continue taking all medications.** This includes Plavix, Coumadin, Pradaxa, Aspirin, or any other similar blood thinners.
- You may continue to take any non-prescription **over the counter** medications or supplements.

If you are on Oxygen- you are responsible to bring enough oxygen to last for the entire day. We do not have a supply of oxygen for patient use.

Smoking will slow healing time and increase chance of complications- stop or greatly decrease the number of cigarettes smoked for 5 days before surgery and for 2 weeks after surgery.

To help with the prevention of infection, we recommend showering with an antibacterial soap the night before or morning of your surgery.

What can I expect after surgery?

- You will leave with a large, bulky dressing called a pressure bandage. This will need to remain in place for 24 hours.
- **You should not participate in any strenuous activity for *at least* one week after surgery**. This includes: **working out, running, sports (even golf and yoga), heavy lifting, yard work and shoveling snow**. By doing these activities, it is possible you may bleed under your stitches which leads to complications. If you have a question about an activity you have planned, please ask!
- Flying in an airplane can complicate your recovery and we request at least 48 hours after surgery before airplane travel.
- Expect bruising and/or swelling. The amount varies person to person and usually lasts for a week or longer. Activity level will greatly contribute to the amount of bruising and swelling.
- We will discuss with you and also send home a detailed instruction sheet about the care of your surgical site.

If you have any further questions, please call our office at 614-847-4100 ext. 31122 or visit our website; www.centerforsurgicaldermatology.com.

If in need of a hotel, we have been given reduced rates at nearby hotels. Please call our office for a list of these hotels or visit the website listed above.

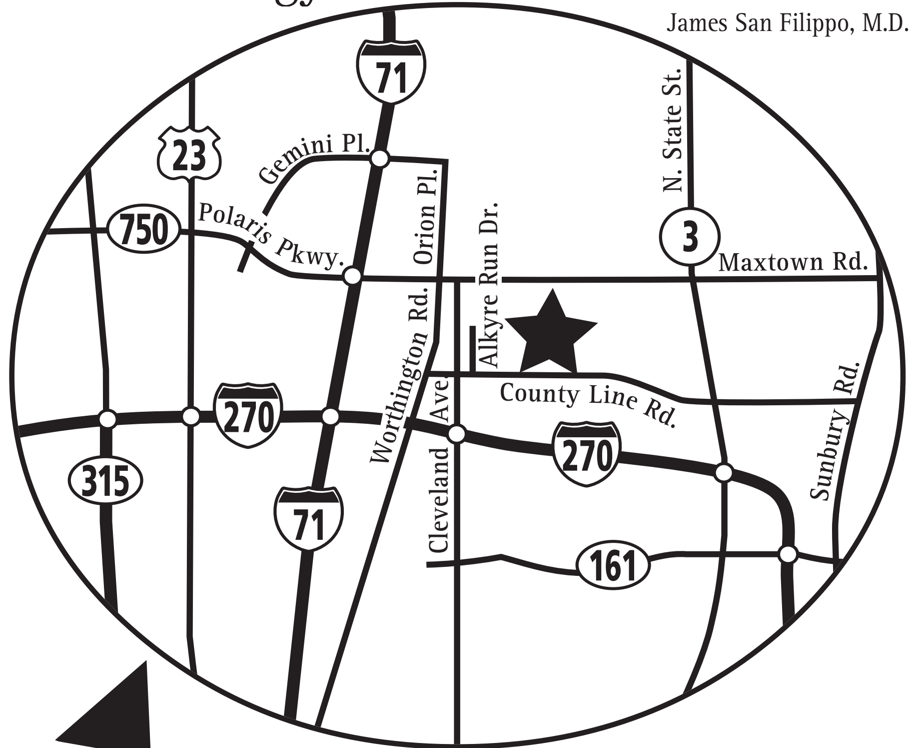
Center for Surgical Dermatology

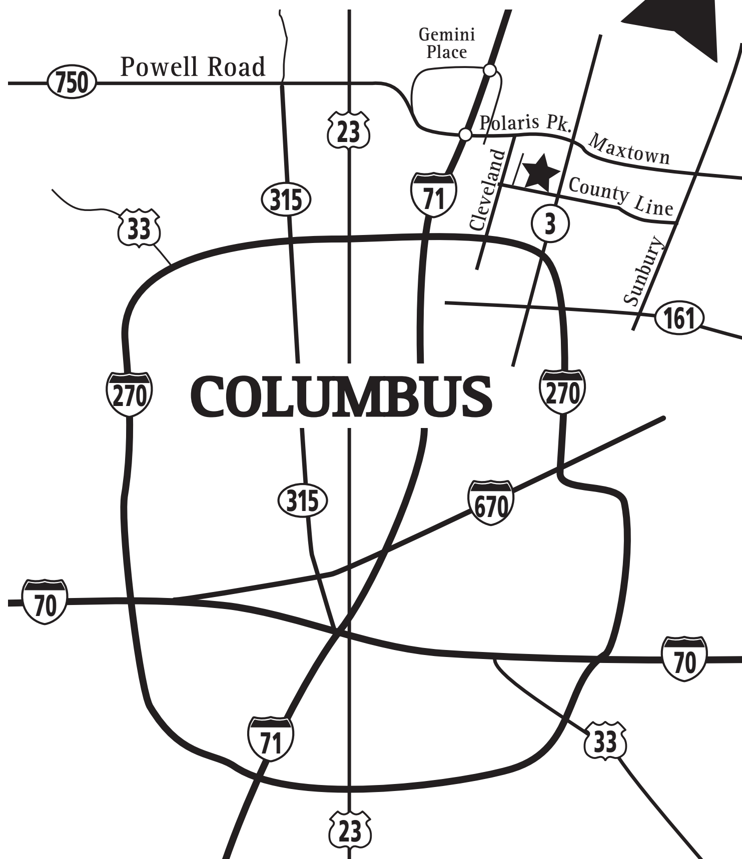
Ronald J. Siegle, M.D.
Brian P. Biernat, M.D.
Peter C. Seline, M.D.
Angela S. Casey, M.D.

Linda S. Rupert, M.D.
Bradley S. Soder, M.D.
Deepa Lingam, M.D.
Nanda Channaiah, D.O.
James San Filippo, M.D.

It's easy to find the Center for Surgical Dermatology & Dermatology Associates

428 County Line Road West
Westerville, Ohio 43082-7027
TEL: 614-847-4100 | FAX: 614-430-1601





We are located north and east of the I-71 & I-270 Interchange about 15 miles north of downtown Columbus.

FROM THE NORTH, exit I-71 at Gemini Place/Polaris Parkway and turn left (East) at the light. Cross over the highway and turn right (South) on Orion Place to Polaris Parkway (0.3 miles). Turn left (East) on Polaris Parkway and go one mile to Cleveland Avenue. Turn right (South) on Cleveland Avenue and go 1/2 mile. Turn left (East) on County Line Road West. Immediately turn left on Alkyre Run Drive and turn right into our parking lot.

FROM THE SOUTH, you have two options.

- The most direct would be to exit I-270 at Cleveland Avenue and go North 2 miles. Turn right on County Line Road West and take the immediate first left onto Alkyre Run Drive and turn right into our parking lot.
- A second option is to stay on I-71 north until Polaris Parkway. Turn right (East) on Polaris Parkway to Cleveland Avenue (Just over 1 mile). Turn right and go 1/2 mile south on Cleveland Avenue. Turn left on County Line Road West. Immediately turn left on Alkyre Run Drive and turn right into our parking lot.

If you are coming from the north side of Franklin County or southern Delaware County it may be helpful to know that Powell Road (Route 750) coming from the west is continuous with Polaris Parkway which as you go east is continuous with Maxtown Road.

CALL US IF YOU NEED DIRECTIONS.
614-847-4100