PRE-OPERATIVE HISTORY & PHYSICAL EXAM

Name: ______ LAST NAME ______ FIRST NAME ______
Male ☐ Female ☐
J #: ______
DOB: ______
Address: ______
______
Telephone: ______
OHIP #: ______

To be completed by the **FAMILY PHYSICIAN**.

Unless otherwise indicated, please fax document to (_____) ______________.

HISTORY OF PRESENT ILLNESS: ______

______

______

PHYSICAL EXAMINATION

Height: ______ Weight: ______ BMI: ______

Blood Pressure: ______ Heart Rate: ______ Findings: ______

ALLERGIES

Allergy	Reaction	Allergy	Reaction

MEDICATIONS (attach a list for additional medications)

Medication	Dose & Frequency	Medication	Dose & Frequency	Anticoagulants		
				ASA 325	☐ Yes	☐ No
				Plavix	☐ Yes	☐ No
				Coumadin	☐ Yes	☐ No
				Other:		

PAST MEDICAL HISTORY

Heart Disease:
High Blood Pressure:
Pulmonary Disease: ☐ Sleep Apnea ☐ CPAP Machine?
Smoking History:
Renal/ Hepatic/ GI Disease:
Endocrine Disease:
Neurologic Disorder:
Personal or Family History of Malignant Hyperthermia:
Other:

PAST SURGICAL HISTORY (Please list all previous surgical procedure(s))	Date of Procedure

Please attach or fax copies of pertinent investigations (e.g. ECG, ECHO, stress test, consultation notes) to Surgeon's Office. History and Physical Examination valid for 12 months from completion.

Physicians Name	Physicians Signature	Date