Blackburn Medical & Esthetics

Minor Procedures – Patient Medical Questionnaire

First Name: _____ Last Name: _____ Age: _____

DOB: _____ Family Physician: _____ OHIP #: _____

1. Do **YOU** have/had any of the following medical conditions?

	Yes	No	Comments or Other Medical Conditions:
Pacemaker or **Implanted Defibrillator**?	☐	☐	
Heart Disease, Heart Attack or **Cardiac Surgery**?	☐	☐	
Stroke, TIA or **Brain Surgery**?	☐	☐	
High Blood Pressure?	☐	☐	
Diabetes?	☐	☐	
Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)	☐	☐	
Possibility of **Pregnancy**?	☐	☐	
Are you **Breastfeeding**?	☐	☐	
Cancer? If yes, please list type/location and treatments:	☐	☐	
Skin Cancer (Melanoma or other)? If yes, please list type, location, and treatments:	☐	☐	
Allergies? If yes, please list them and their reaction:	☐	☐	
Reaction to Local Anesthetic? If yes, please list them and their reaction:	☐	☐	

2. Do you have a **FAMILY HISTORY** of **Cancer** or **Skin Cancer**? ☐ Yes ☐ No
   If yes, please list type, location, and family member:

3. Do you take any **Blood Thinners** (Aspirin, Coumadin, Eliquis, Xarelto, etc.)? ☐ Yes ☐ No
4. Do you have a **Medication List** that you will show to the Doctor? ☐ Yes ☐ No
   If no, please list all Medications:

5. Please list all **Surgeries/Operations** or **Admissions** to a Hospital (please include the **date**):

6. Do you smoke tobacco? ☐ Yes ☐ No If yes, how much? _____
7. Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____
8. Do you consume cannabis or other drugs? ☐ Yes ☐ No If yes, how much? _____

_____
Signature Date

Thank you for your cooperation. This information will be included in your medical record.

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