



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?	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease, Heart Attack or Cardiac Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke, TIA or Brain Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	
Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)	<input type="checkbox"/>	<input type="checkbox"/>	
Possibility of Pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	
Breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	
Skin Cancer (Melanoma or other)? If yes, please list type, location, and treatments:	<input type="checkbox"/>	<input type="checkbox"/>	
Other Cancer? If yes, please list type, location and treatments:	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies? If yes, please list them and their reaction:	<input type="checkbox"/>	<input type="checkbox"/>	
Reaction to Local Anesthetic? If yes, please list them and their reaction:	<input type="checkbox"/>	<input type="checkbox"/>	

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.