PLEASE COMPLETE AND FAX TO: 250-595-8835

clinic805
COSMETIC SURGERY & SKINCARE CENTRE

PRESURGICAL HISTORY FORM

805 Fairfield Road, Victoria, BC
Ph: 250-595-3888

Patient Name: **DOB:**
PHN: **Address:**

Surgery Date:
Surgeon: **Dr. Kenneth A. Smith**

Procedure:

SYSTEMS REVIEW

E.E.N.T.:
Cardiovascular:
Respiratory:
Renal:
GERD:
Endocrine:
Neuro-psych:
Haematological:
Tobacco:
Alcohol:

PAST HISTORY

Medical:
Allergies:

Surgical:

Any previous anaesthetic problems ☐Self? / ☐Family? :
Any previous history of MRSA?
Medications (including dosages):

PHYSICAL EXAM

Height: **cm** **Weight:** **kg** **BMI>30** ☐**YES** ☐**NO** **Blood Pressure:**

Head & Neck:
Pregnant: ☐No ☐Yes Due date:
Chest:
Cardiovascular:
Abdomen:
GU:
Extremities:
CNS:

ASSESSMENT:

ASA ☐**1** ☐**2** ☐**3 (check please)**

TODAY'S DATE

PHYSICIAN NAME (pls print) & SIGNATURE

Physician Stamp: