Name: _____

Date of Birth: _____ Age: _____

OHIP #: _____ Version Code: (2 letters) _____

Home Address: _____

City: _____ Province: _____ Postal Code: _____

Best Phone Number to Contact You: _____

Email Address: _____

How would you prefer we contact you? (Please Circle) Phone / Email

Reason for Visit: _____

Have you had a previous Cosmetic Surgeon's opinion regarding today's consultation? If Yes, Who?_____

List of any medications you are taking: _____

List of any medical conditions and previous operations:

_____

List of any drug allergies: _____

Are you presently, or have you ever been under the care of a psychiatrist? Yes / No

Do you smoke tobacco products? Yes / No

Do you have a history of any of the following medical conditions?

Diabetes	Yes / No	Phlebitis	Yes / No
High Blood Pressure	Yes / No	Malignant Hyperthermia	Yes / No
Heart Disease	Yes/ No	Anesthesia Problems	Yes / No
Disorders	Yes / No	Bleeding/Clotting	Yes / No

How did you hear about us?

_____

Do you have medical benefits? Yes / No

Have you read over our cancellation policy? Yes / No

Signature: _____ Date: _____