Peter Brownrigg MD. F.R.C.S.(C)
Cosmetic and Reconstructive
Facial Plastic Surgery
Otolaryngology

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Name:________________________________ Age: __________

Date Of Birth:________________________________ (Year/ Month/ Day)

OHIP #:__________________Version code_____ Expiry date__________

Home Address:____

City:________________ Province: _____________Postal Code: ________

Home Telephone : ______________ Work Telephone :________________

E-Mail Address:____

Do we have permission to send confidential medical information by E-Mail? (EX: appointment reminders etc.) YES_______ NO_______

General Questions:

1. Family Physician: _______________2. Reason for Visit: _______________

3. Have you had a previous cosmetic Surgeon's opinion regarding today's consultation? If Yes, Surgeon's Name:____________________________________

4. List any medications you are currently taking:________________________

5. List any medical conditions, and previous operations:____________________

6. List any drug allergies:______________________________________

7. Are you presently, or have you ever been under the care of a psychiatrist? Yes____ No ___

8. Do you smoke tobacco products regularly? Yes_____ No _____

9. Do you have a history of any 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

10. How often do you take aspirin (ASA)? ____________________________

11. How did you hear about us? ________________________________

Signature:______________________________Date:______________