Name: _____

Address: _____

Phone #: _____

Record #: _____

MHSC# _____

Date of Birth: _____

PLEASE CC: _____FAX 204.885.1552

Laboratory (please check if requested):

☐ CBC ☐ Electrolytes

☐Glucose ☐ LFT's

☐ Coags ☐ Urea/Creatinine/eGFR

Mandatory requirements:

EKG if >50yrs ☐

CXR if >65yrs ☐

Surgical Procedure:	Date of Surgery:

Past Medical History:

Alcohol consumption: _____

Marijuana usage: _____

Smoker Y☐ N☐ ___/ppd

Family History ☐ Cancer ☐ Cardiovascular ☐ Other

Previous Surgeries: Y☐ N☐ _____

Family History of Anesthetic Problems	☐ No	☐ Yes	Comment
Past History of Anesthetic Problems	☐ No	☐ Yes	Comment
History of Malignant Hyperthermia	☐ No	☐ Yes	Comment
History of Pseudocholinesterase Deficiency	☐ No	☐ Yes	Comment

Current Medications/Supplements:	Allergies/Reactions:

Blood/Body Precautions	No	Yes		No	Yes
Recipient of blood transfusion	☐	☐	Hepatitis positive	☐	☐
Refused as blood donor	☐	☐	HIV positive	☐	☐

Past medical history/review of systems

Cardiovascular

	No	Yes	Inactive	Comments
angina/chest pain				
exercise limitation				
previous MI				
heart failure				
murmur				
arrhythmia				
hypertension				
peripheral vascular disease				
pace maker				
other				

Gastrointestinal

	No	Yes	Inactive	Comments
hiatus hernia/reflux				
peptic ulcer				
melena				
hematemasis				
abdominal pain				
inflammatory bowel disease				
jaundice				
other				

Respiratory				
	No	Yes	Inactive	Comments
asthma/wheezing				
COPD				
dyspnea				
hemoptysis				
sleep apnea				
other				

Neurological				
	No	Yes	Inactive	Comments
headache				
TIA/CVA				
seizures				
developmental delay				
cognitive impairment				
other				

Musculoskeletal				
	No	Yes	Inactive	Comments
osteoarthritis				
rheumatoid arthritis				
other				

ENT				
	No	Yes	Inactive	Comments
sinusitis				
visual impairment				
hearing deficits				

Dermatology				
	No	Yes	Inactive	Comments
skin rash				
skin cancer				

Genito-Urinary				
	No	Yes	Inactive	Comments
dysuria				
hematuria				
renal disease				
menstrual cycle				lnmp
other				

Hematological				
	No	Yes	Inactive	Comments
bleeding disorder				
anemia				
other				

Endocrine				
	No	Yes	Inactive	Comments
diabetes				
thyroid disease				
other				

Mental Health				
	No	Yes	Inactive	Comments
depression/anxiety				
other				

Physical Examination

Height	Weight	Heart Rate	B.P.	Temp.

	Normal	Abnormal	Comments
general appearance			
head and neck			
central nervous system			
respiratory			
cardiovascular			
breasts			
abdomen			
back & extremities			
skin			
lymph nodes			
pelvic/external genitalia			

ASA Classification 1 2 3 4 5 (Circle one)

Date of examination:_____ Examining Physician/Nurse Practitioner: _____

Phone:_____ Address:_____ Signature: _____

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THE FIRST GLANCE AESTHETIC CLINIC & SURGERY CENTRE