JEFFREY C. DAWES MD, FRCSC
PLASTIC AND DERMATOLOGIC SURGERY

Patient Label   Healthcare Number ________________

Height__________ Weight_________ BMI________

SEX   M   F   EMAIL ADDRESS ____

Referring Physician or Family Physician ____

Reason for your visit today ____

If referred by a friend or family member, who can we thank? _________________________________

Circle any of the following medical conditions which you have or for which you have been treated:

DIABETES   EPILEPSY/SEIZURES   ASTHMA   ARTHRITIS   AIDS/HIV   CANCER   BLEEDING DISORDER
LUPUS   THYROID DISORDER   HEART/CARDIAC   ANAESTHETIC REACTION   HEPATITIS

Please list any other medical conditions you have ____

Do you have any issue with receiving blood products if needed   Y   N

Do you smoke Y N   if so how much ______________   Women: Are you pregnant Y N

Food or Drug Allergies ____

Have you ever had surgery Y N
If yes, were there complications ____

Please list any previous surgeries you have had ____

____

List significant family history of medical conditions ____

____

Have you every had a blood transfusion Y N
If yes, were there complications____

Is your Physician currently treating you? Y N
If yes, please give details ____

Please list all medications you are taking ____

____

Pharmacy name and address/phone/fax ____

Please circle if you are interested in receiving additional information regarding any of the following:

NON-INVASIVE FAT REDUCTION(COOLSCULPTING)   WRINKLE REDUCTION   ROSACEA
GLOMINERALS MAKEUP   BELKYRA   EYELASH GROWTH (LATISSE)   FACIALS   SKINCARE
ACNE SCARS   NEUROMODULATORS(BOTOX/XEOMIN)   HAND REJUVENATION   LASER   FILLERS
CHEMICAL PEELS   FACIAL RESURFACING   LASER HAIR REMOVAL   SKIN PIGMENTATION

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