To be completed by the patient and returned to Dr. Anzarut's office [fax:250-597-1297 or email: dranzarutplastics@gmail.com]

surgical centres inc

Seafield Surgical Centre
Health History Questionaire

Date: _____
Name: _____
OR Date: _____
Surgeon: Alexander Anzarut
Height: _____ **Weight** _____

Do you have OR have you ever had:

	Yes	No		Yes	No
High Blood Pressure			Kidney Problems/Dialysis		
Congestive Heart Failure			Bleeding Disorders		
Abnormal Heart Rhythm			Diabetes		
Previous Heart Attack			Thyroid Problems		
Sleep Apnea (do you use CPAP at home)			COPD		
Hiatus Hernia			Asthma		
Symptoms of Heartburn			Emphysema		
Epilepsy/Seizures			Back/Neck/Joint problems		
Liver Problems			Stroke		
Hepatitis B or C			Rheumatoid Arthritis		
Antibiotic Resistant Organisms (ARO/MRSA)			HIV		

	Yes	No	
Have you smoked in the past 12 months?			Amount_____
Do you use Marijuana?			Amount?_____
Do you drink Alcohol?			Amount?_____
Have you ever used street drugs?			

Name of drug: _____
Last use: _____

Have you ever had Anesthetic before? YES/ NO When was the last time? _____
Previous surgeries: _____
Have you had problems with anesthetics in the past? YES/NO
If yes, please explain: _____
Has a family member had problems with anesthetics? YES/NO
If yes, please explain: _____

MEDICATION/VITAMINS/NATURAL/HERBAL SUPPLEMENTS currently taking:

Name of Drug	Dose	Last taken

ALLERGIES / REACTION:

Name of responsible adult driver:	Phone:

Pre-operative history and physicals for cosmetic surgery are not insured services through MSP and should be billed directly to the patient. The patient is aware.

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FAX (250)-741-0225

PRE-SURGICAL HISTORY & PHYSICAL

NAME: _____

DATE OF SURGERY _____

SURGEON Alexander Anzarut, MD

PRE-OPERATIVE DIAGNOSIS: _____

REVIEW OF SYSTEMS:

E.E.N.T.
Cardiovascular:
Respiratory:
Genito-urinary:
Gastro-intestinal:
ALLERGIES:

Endrocrine:
Neuro-psych:
Hematological:
Tobacco Use:
Alcohol Use:
Obstructive Sleep Apnea/CPAP:

FAMILY MEDICAL HISTORY:

PATIENT HISTORY:

MEDICAL:

SURGICAL

MEDICATIONS: _____

PHYSICAL EXAMINATION: BMI: _____

B.P_____ RESPIRATIONS_____ PULSE_____WEIGHT_____HEIGHT_____

Head & Neck:
Lymph Nodes:
Chest:
C.V:
Abdomen:
G.U:
Extremities:
C.N.S:

ASSESSMENT SUMMARY:

PRE-OP TESTS ORDERED: _____

ALL PATIENTS OVER THE AGE OF 50 MUST HAVE AN ECG

Date _____ Signature of physician _____ Physician (print name) _____

Please FAX DIRECTLY TO SEAFIELD SURGICAL CENTRE (250)-741-0225 from your office , fax to Dr Anzarut (250)597-1297 / dranzarutplastics@gmail.com and provide a copy to the patient