DR. RONNIE BORSUK, MD CM, FRCS (C)
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Ottawa ON, K2A 3Z3

Dear Patient: *Kindly complete this health questionnaire to the best of your ability. Please print clearly.*

Name: _____ ☐ **M** ☐ **F** **Health Card**: _____
(Including letters)

DOB: _____ **Home:** _____ **Cell:** _____ **Work:** _____

Address: _____ **City**: _____ **Postal Code**: _____

Preferred language:
Email: _____ ☐ **English** ☐ **French** ☐ **Other**: _____

***May we use the above email address to communicate regarding consult, follow-up and surgery related matters*? ☐ Y ☐ N**

May we us the above email address to communicate with you for promotional related matters? ☐ **Y** ☐ **N**

Height: _____ (feet/inches or cm) **Weight**: _____ (lbs or kgs) **BMI:** _____
(For office use only)

Family Physician: _____ **Tel:** _____ **Your Profession**: _____

Medications: _____ **Drug Allergies**: _____

or Vitamins _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you take aspirin or any other blood thinner? (Specify) **Other Allergies (i.e. latex, eggs or other foods, metal)**

_____ _____

_____ _____

Do you take any estrogen containing medication? *(You may need to stop 6 weeks pre-operatively)*

_____

Do you smoke tobacco of any kind?

☐ **Yes** ☐ **No** **How much?** _____ **For how many years?** _____

Your Pharmacy Name and Phone Number: _____

PAST MEDICAL HISTORY (i.e. Heart, Breathing, Blood problems, Neurological, Other):

PMH	Yes	No	Not Sure	Comments
1. Do you have a pacemaker?				
2. Do you have any heart problems?				

PMH continued…	Yes	No	Not Sure	Comments
3. Do you have sleep apnea?				
4. Do you have a sleeping machine to help you sleep?				
5. Do you have breathing problems?				
6. Do you have diabetes?				
7. Do you have high blood pressure?				
8. Do you have high cholesterol?				
9. Do you have chronic pain?				
10. Do you or your family have history of blood clots?				
11. Have you had 3 or more miscarriages?				
12. Do you or your family have serious problems following an anesthetic?				

Do you have any other illness, limitations or any other concerns we should know about? ☐ **Yes** ☐ **No**

Specify: _____

LIST ANY SURGERIES OR MINOR PROCEDURES USING ANESTHETIC YOU HAVE HAD IN THE PAST

Procedure	Year
1.	
2.	
3.	
4.	

LIST ANY OTHER UPCOMING PROCEDURES (other than your surgery) AND WHEN THEY ARE SCHEDULED?

Procedure	Month/Year
1.	
2.	
3.	

Patient Health Questionnaire completed by:

☐ **Patient** ☐ **Family Member** ☐ **Health Care Provider** ☐ **Other (specify)**: _____

Print name(s)	Signature	Date (yyyy/mm/dd)

IMPORTANT: Please remember to let your surgeon know if you think you are getting a cold, flu or illness or if you start taking any new medications.