PRE-OPERATIVE HISTORY & PHYSICAL EXAM

ST JOSEPH'S HEALTH CENTRE TORONTO

Name: _____ (LAST NAME) _____ (FIRST NAME)
Male ☐ Female ☐
J #: _____
DOB: _____
Address: _____
_____
Telephone: _____
OHIP #: _____

To be completed by the **FAMILY PHYSICIAN**.

Unless otherwise indicated, please fax document to (_____) _____.

HISTORY OF PRESENT ILLNESS: _____

_____

_____

PHYSICAL EXAMINATION

Height: _____ Weight: _____ BMI: _____

Blood Pressure: _____ Heart Rate: _____ Findings: _____

ALLERGIES

Allergy	Reaction	Allergy	Reaction

MEDICATIONS (attach a list for additional medications)

Medication	Dose & Frequency	Medication	Dose & Frequency	Anticoagulants		
				ASA 325	☐ Yes	☐ No
				Plavix	☐ Yes	☐ No
				Coumadin	☐ Yes	☐ No
				Other:		

PAST MEDICAL HISTORY

Heart Disease:
High Blood Pressure:
Pulmonary Disease: ☐ Sleep Apnea ☐ CPAP Machine?
Smoking History:
Renal/ Hepatic/ GI Disease:
Endocrine Disease:
Neurologic Disorder:
Personal or Family History of Malignant Hyperthermia:
Other:

PAST SURGICAL HISTORY (Please list all previous surgical procedure(s))	Date of Procedure

Please attach or fax copies of pertinent investigations (e.g. ECG, ECHO, stress test, consultation notes) to Surgeon's Office. History and Physical Examination valid for 12 months from completion.

Physicians Name	Physicians Signature	Date