Peter Brownrigg MD. F.R.C.S.(C)
Cosmetic and Reconstructive
Facial Plastic Surgery
Otolaryngology

Carling Executive Park
1525 Carling Avenue, Suite 608
Ottawa, Ontario K1Z 8R9
Tel. (613) 724-1214
Fax (613) 724-1240
www.drpbrownrigg.ca

Name:______________________________ **Age:** ____________

Date Of Birth:______________________________ **(Year/ Month/ Day)**

OHIP #:____________________**Version code**_______ **Expiry date**______________

Home Address:____

City:________________ **Province:** ______________**Postal Code:** __________

Home Telephone : __________________ **Cellular :**______________________

E-Mail Address:____

Do we have permission to send confidential medical information by E-Mail? (EX: appointment reminders etc.) YES_________ **NO**_________

General Questions:

1. Family Physician: ____________________**2. Reason for Visit:** ____________________

3. Have you had a previous cosmetic Surgeon's opinion regarding today's consultation? If Yes, Surgeon's Name:______________________________________

4. List any medications you are currently taking:______________________________

____

____

5. List any medical conditions, and previous operations:______________________

____

____

6. List any drug allergies:____

7. Are you presently, or have you ever been under the care of a psychiatrist? Yes____ **No** ___

8. Do you smoke tobacco products regularly? Yes_____ **No** _____

9. Do you have a history of any of any of the following medical conditions?

Diabetes	Yes/No	Phlebitis	Yes/No
High Blood Pressure	Yes/No	Malignant Hyperthermia	Yes/No
Heart Disease	Yes/No	Anesthesia Problems	Yes/No
Disorders	Yes/No	Bleeding/Clotting	Yes/No

10. How often do you take aspirin (ASA)? ______________________________

11. How did you hear about us? ______________________________________

Signature:______________________________ **Date:**______________