DR. COLIN McINNES
PLASTIC SURGERY

Breast Consultation

Name: _____
Phone number: _____
Email address: _____
☐ Yes, I would like to be added to Dr. McInnes' e-newsletter for more information
Age: _____ Date of birth: _____
Height: _____ Weight: _____ BMI (office use only): _____
Occupation: _____
Where did you hear about Dr. McInnes?
☐ Instagram ☐ Facebook ☐ Online (eg. google)
☐ Family physician ☐ Another patient
☐ Other (please list): _____

I am seeking a breast: AUGMENTATION | REDUCTION | LIFT | IMPLANT REMOVAL | TOP SURGERY

Current cup size and under bust: _____

Desired cup size and under bust: _____

Is your weight stable: YES | NO Highest weight: _____ Lowest weight: _____

Have you had children: YES | NO

Do you plan on any additional children: YES | NO

Did you breast feed: YES | NO

Do your breasts cause you any symptoms (describe): _____

Have you ever had a mammogram: YES | NO
- If yes, have there ever been any abnormalities (describe)?

Have you ever found a lump in your breast: YES | NO

Have you ever had bleeding from your breasts: YES | NO

Do you have a family history of breast cancer: YES | NO

Do you have any unrelated cosmetic surgery treatment interests or questions: YES | NO
Please list: _____

Do you have any allergies: YES | NO _____(describe)

307 – 233 Nelson's Crescent, New Westminster, BC, V3L 0E4
TEL: 604-515-8847 WEBSITE: www.doctorm.ca EMAIL: office@doctorm.ca
Plastic, reconstructive, and aesthetic surgery

Do you/have you ever had any of the following: YES | **NO TO ALL**

Cancer	YES | NO	_____ (list)
Stroke / TIA	YES | NO	_____ (list)
Heart attack / heart condition	YES | NO	_____ (list)
Pacemaker	YES | NO	_____ (list)
High blood pressure	YES | NO	_____ (list)
Diabetes	YES | NO	_____ (list)
Blood clot (ie. DVT)	YES | NO	_____ (list)
Leg swelling	YES | NO	_____ (list)
Sleep apnea / CPAP machine	YES | NO	_____ (list)
Asthma / respiratory condition	YES | NO	_____ (list)
Kidney disease	YES | NO	_____ (list)
Eye disease/disorder	YES | NO	_____ (list)
Bleeding disorder	YES | NO	_____ (list)
Anemia	YES | NO	_____ (list)
Problems with anesthesia	YES | NO	_____ (list)
Psychiatric condition	YES | NO	_____ (list)
Blood born illness:	YES | NO	_____ (list)
Illicit drug use:	YES | NO	_____ (list)

Other: _____(list)

Surgical history (list all surgeries including the dates):

_____

_____

Current Medications (please list all medications):

Blood thinners:

ASPIRIN | PLAVIX | WARFARIN | XARELTO (rivaroxaban) | FISH OIL | HERBAL SUPPLEMENTS

Steroids: _____(list)

Diabetes medications: _____(list)

Immune suppressing medications: _____(list)

Others (including vitamins & supplements): _____(list)

Do you smoke or vape: YES | NO | FORMER SMOKER

___cigarettes / day

___daily vape

___marijuana joints / day

Drinks per week (on average): _____and

Please note, the use of fish oil and ANY herbal supplements can be associated with significant bleeding during and after surgery.

SIGNATURE: _____

DATE (D/M/Y): _____

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