DR. COLIN McINNES

PLASTIC SURGERY

Lesion / Mass Consultation

Name: _____

Age: _____

Occupation: _____

Phone number: _____

Email address: _____

☐ Yes, I would like to be added to Dr. McInnes' e-newsletter for more information

Where is the lesion/mass located? _____

How long has the lesion/mass been present: _____

Has it changed recently: YES | NO

If yes, describe: _____

Has the lesion caused you any notable problems: YES | NO

If yes, describe: _____

Medical history (circle)

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)
Kidney disease	YES | NO _____	(list)
Eye disease/disorder	YES | NO _____	(list)
Bleeding disorder	YES | NO _____	(list)
Anemia	YES | NO _____	(list)
Blood clot (ie. DVT)	YES | NO _____	(list)
Sleep apnea / CPAP machine	YES | NO _____	(list)
Asthma / respiratory condition	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)

Do you have any allergies: YES | NO_____ (list)

Do you take blood thinners: YES | NO _____(list)

Do you take fish oil or herbal supplements: YES | NO

Do you take steroids or other immune suppressing medication: YES | NO_____(list)

Do you smoke (cigarettes, marijuana, or vape): YES | NO | FORMER SMOKER

SIGNATURE: _____

DATE (D/M/Y): _____

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Reconstructive & Cosmetic Plastic Surgery