



# DR. COLIN MCINNES

## PLASTIC SURGERY

### Abdomen Consultation

Name: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email address: \_\_\_\_\_

☐ Yes, I would like to be added to Dr. McInnes' e-newsletter for exclusive offers and updates!

Age: \_\_\_\_\_

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 an abdominal: ABDOMINOPLASTY | PANNICULECTOMY | LIPOSUCTION | BODY LIFT

Is your weight stable: YES | NO

Highest weight: \_\_\_\_\_ Lowest weight: \_\_\_\_\_

Is your diet & exercise stable: YES | NO

Have you had children: YES | NO

Do you plan on any additional children: YES | NO

How many times have you been pregnant: \_\_\_\_\_

Have you had a c-section or any type of abdominal surgery: YES | NO

Describe: \_\_\_\_\_

Have you ever have an abdominal hernia: YES | NO

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

Medical history → 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)

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

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)  
**Allergies** YES | NO \_\_\_\_\_ (list)  
 Other: \_\_\_\_\_ (list)

Surgical history (list all surgeries including the dates):

\_\_\_\_\_

Current Medications (please list all medications including supplements)

Blood thinners: ASPIRIN | PLAVIX(clopidogrel) | WARFARIN | XARELTO (rivaroxaban) \_\_\_\_\_ (list others)

Steroids: \_\_\_\_\_ (list)

Diabetes medications: \_\_\_\_\_ (list)

Immune suppressing medications: \_\_\_\_\_ (list)

**Others** (including vitamins & supplements): \_\_\_\_\_ (list)

Do you smoke: YES | NO | FORMER SMOKER

\_\_\_cigarettes / day

\_\_\_marijuana joints / day

Drinks per week (on average): \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**DATE (D/M/Y):** \_\_\_\_\_