DR. COLIN McINNES
PLASTIC SURGERY

Face & Neck 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 interested in (circle): FACELIFT | NECK CONTOURING | EYELID SURGERY | UPPER LIP LIFT | CHEEK/JAWLINE SLIMMING | EAR SURGERY | RHINOPLASTY | CHIN AUGMENTATION | BOTOX & FILLER

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

Is your diet & exercise stable: YES | NO

Do you have any problems with your vision, eyes, or tearing: YES | NO
Describe: _____

Do you use a CPAP machine: YES | NO

Do you have any respirator problems: YES | NO
Describe: _____

Have you had any previous facial surgery +/- cosmetic treatments (eg. Botox & filler): YES | NO
Describe: _____

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)
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): _____