

DR. COLIN MCINNES

PLASTIC SURGERY

Hand / Peripheral Nerve Consultation

Name: _____ Current date (D/M/Y): _____

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: _____

Which hand do you write with: LEFT | RIGHT

Which hand did you injure: LEFT | RIGHT

Which finger did you injure: THUMB | INDEX | MIDDLE | RING | SMALL

Have you ever injured your current hand before: YES | NO _____ (explain)

How many days ago did you injure your hand: _____

How did you injure your hand?

Current pain (out of 10): ____ / 10

Did the injury occur at work? YES | NO (WBC claim number: _____)

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)

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)

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Plastic & Reconstructive Surgery

Psychiatric condition YES | NO _____ (list)
Blood born illness: YES | NO _____ (list)
Illicit drug use: YES | NO _____ (list)
Other: _____ (list)

Allergies YES | NO _____ (list)

Surgical history (list all surgeries including the dates):

Current Medications (please list all medications)

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): _____