

# DR. COLIN MCINNES

## PLASTIC SURGERY

### Lesion / Mass Consultation

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

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

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

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

- Yes, I would like to be added to Dr. McInnes' e-newsletter for exclusive updates! (op-out option available)

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)

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

Other: \_\_\_\_\_ (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