TOSC

TORONTO OUTPATIENT SURGERY CENTRE

Patient Information

Patient Name (Last, First):_____

Date of Birth: _____

Health Card: _____ VC: _____

Patient Phone Number:_____

Medical History Form

Height: _____ **Weight:** _____ **BMI:** _____ **DATE:** _____

Vitals **BP:** _____/_____ **HR:** _____ **O_2 :**_____ **Temp:** _____

Relevant Medical History ☐ No ☐ Yes ☐ N/A (if yes, please specify):

_____

_____

_____

_____

Drug Allergies ☐ No ☐ Yes (if yes, please specify):

_____

_____

Surgical History (please specify):

_____ _____

_____ _____

Relevant Physical Exam ☐ No ☐ Yes ☐ N/A (if yes, please specify):

_____

_____

_____

_____

Smoking ☐ No ☐ Yes (if yes, please specify):

How Long: _____ Months _____ Years ☐ Quit, when: _____

How Often: _____cigarettes _____ times per day

ETOH ☐ No ☐ Yes (if yes, please specify):

How Often: _____ # of times per week

Medications (please specify): ☐ Not Current Taking

_____ _____ _____

_____ _____ _____

_____ _____ _____