ENT VANCOUVER

Name (full legal) ____
First name Family name/Surname

Date of birth ____________________________ Male Female Other
(month/day/year)

Care Card (PHN) # ___________________________ (indicate the province/territory if not BC)

Address ____

City _______________________________ Postal Code ___________________

Daytime phone #1 ________________ #2 __________________

Email _____________________________ Permission to contact by email? YES NO

Alternate contact name & phone # ______________________________________

Family physician __________________ Referring physician __________________

Occupation _____________________ Employer _______________________

Reason for your visit ____

Medical History (please check) Height _________ Weight _________

diabetes	bad scarring	Other (specify)
hepatitis	anemia/bleeding disorder	
HIV	obstructive sleep apnea	______________________
high blood pressure	difficulty with anesthetic	
heart disease	autoimmune disorder	______________________
head injury/seizures	radiation therapy	
acid reflux	asthma/COPD	______________________
kidney disease	cancer	

Past surgery ____

____

Medications ____

____

Allergies (drug/other) ____

Smoking history ___ packs per day x ___ years Currently smoking OR Quit date __________

Alcoholic drinks per day __________________