# GENERAL QUESTIONNAIRE

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E-mail : drbernier@drbernier.com

Last Name at birth : _____ First Name : _____ Gender : F ☐ M ☐

Birthday : _____ Medical card number: _____ Exp : _____

Perm. Address : _____ City : _____ Province/State/County : _____

Postal Code : _____ Country : _____ E-mail : _____

Telephone res. : _____ Telephone Work : _____ Ext. : _____ Cell. : _____

Occupation : _____

Reason of consultation/ predicted surgery : _____

**REFERENCES :**

- ☐ Patient known from the clinic
- ☐ Canadian Society for Aesthetic (cosmetic) plastic surgery
- ☐ American Society of Plastic Surgeons
- ☐ Recommendation of another MD
- ☐ Association des spécialistes en chirurgie plastique et esthétique du Québec
- ☐ Canadian Society of Plastic Surgeons
- ☐ Recommendation of a friend or relative
- ☐ Magazine. Specify :
- ☐ Internet/Google
- ☐ Instagram
- ☐ Facebook
- ☐ ChatGPT

## MEDICAL INFORMATION

***The following informations are necessary for the evaluation of your health. Please answer all the questions.***

| Personal History: | YES | NO |
|---|---|---|
| Cancer | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Neurological disease | ☐ | ☐ |
| Cardivascular disease | ☐ | ☐ |
| Pulmonary disease | ☐ | ☐ |
| V Leiden Factor | ☐ | ☐ |
| Hogh cholesterol level | ☐ | ☐ |
| Arterial hypertension | ☐ | ☐ |
| Hypothyroidism | ☐ | ☐ |
| Hyperthyroidism | ☐ | ☐ |
| Phlebits | ☐ | ☐ |
| Varicose vein | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Phychiatric illness | ☐ | ☐ |
| Cold sore | ☐ | ☐ |
| Hepatitis B | ☐ | ☐ |
| Hepatitis C | ☐ | ☐ |
| HIV | ☐ | ☐ |
| Sleep apnea | ☐ | ☐ |
| Excessive bleeding | ☐ | ☐ |
| Food allergy or other allergy | ☐ | ☐ |
| Latex allergy | ☐ | ☐ |
| Medication allergy | ☐ | ☐ |
| Medication intolerance | ☐ | ☐ |
| Prescribed medicine : | ☐ | ☐ |
| Medical history : | ☐ | ☐ |
| Surgical history : | ☐ | ☐ |

| Previous Family History | YES | NO | Unknown |
|---|---|---|---|
| Thrombophlebitis | ☐ | ☐ | ☐ |
| V Leiden Factor | ☐ | ☐ | ☐ |
| Pulmonary embolism | ☐ | ☐ | ☐ |
| Anesthesia problem | ☐ | ☐ | ☐ |
| Hyperthermia Malignant | ☐ | ☐ | ☐ |

| Consumption | Quantity |
|---|---|
| Alcohol | |
| Cigarettes or Vape | |
| Marijuana | |
| Drugs? Specify: | |

**Pharmacy**

Phone: _____

Name: _____

Address:

Weight _____ pds _____ kg

Height _____ ft _____ cm

**For women**

Number of on term pregnancies

Number of non-term pregnancies

Number of premature pregnancies

**Notes**

**Please save the file using the button below, then email it to drbernier@drbernier.com.**
**Do not print this form.**
**We will ask you to sign the form during your visit.**

- ☐ *I declare that the information supplied in this form is sincere and complete. I understand that a false statement can entail serious consequences in case of surgery or treatment.*
- ☐ *A photo identification card is required.*
- ☐ *So that Dr Bernier could diagnose with the best of his knowledge, expertise and experience, I consent to undergo a physical examination.*
- ☐ *In any case, the consultation fees will not be reimbursed, even if no surgery is recommended.*
- ☐ *In case of e-mail communication with Dr Bernier and/or his employees, I am aware of risks of breaking of confidentiality of exchange of information.*

CLINIQUE DE CHIRURGIE ET MÉDECINE ESTHÉTIQUE
Dr Mario F. Bernier

**Signature** _____ **Date** _____

Save