GENERAL QUESTIONNAIRE

3030, boul. Le Carrefour, Bur. 500,
Laval (Quebec) Canada H7T 2P5

Tel : 450 686-4755 • Fax : 450 686-4733
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
- ☐ Yellow Pages

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	☐	☐
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	☐	☐	☐

Covid-19	YES	NO
Fever	☐	☐
Sore throat	☐	☐
Cough	☐	☐
Loss of smell	☐	☐
Loss of taste	☐	☐
Breathing difficulties	☐	☐
Have you had Covid-19 (test +)	☐	☐
Hospitalization	☐	☐
Contact with an infected person	☐	☐

Consumption	Quantité
Alcohol	_____
Cigarettes or Vape	_____
Marijuana	_____
Drugs? Specify :	_____

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 with the button below and send it by email to drbernier@drbernier.com. Do not print this form. We will have you sign the form at your next visit at our clinic.

- ☐ *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.*

Signature _____ **Date** _____

CLINIQUE DE CHIRURGIE ET MÉDECINE ESTHÉTIQUE
Dr Mario F. Bernier

Save