DR. CHRISTOPHER D. ZROBACK **M.D., F.R.C.S.C.**

GENERAL SURGERY & ENDOSCOPY

604-391-2000 604-393-9779

Patient Name: LAST NAME, FIRST NAME Family Doctor: _____

Care Card #: PHN # Date of Birth: MM/DD/YYYY

Address: UNIT # STREET # STREET NAME

TOWN/CITY PROVINCE POSTAL CODE

Phone #: _____ Alternate Contact #: _____

Past Medical History Questionnaire

☐ High Blood Pressure ☐ Heart Problems ☐ Diabetes ☐ Lung/Breathing Problems

☐ Bleeding Problems/Blood Thinners ☐ Sleep Apnea ☐ Cancer ☐ Problems with Anesthesia

Height: _____ cm OR ft/in Weight: _____ kg OR lbs

Please list any other medical conditions:

Please list any previous operations/surgeries:

Please list current medications:

Please list any medication/drug allergies:

Have you ever smoked? (circle one) Yes No If yes, please describe: _____

Number of alcohol drinks per week? _____

FOR OFFICE USE ONLY

R _____ L _____

HPI

PMH: SX: MX:

FAMILY HX:

SOCIAL HX:

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