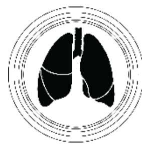

York Thoracic Surgery

FIRST VISIT FORM

DATE: MM____/DD___/YYYY________

Family Dr.: ______________________________
Location: ______________________________
Contact #: ______________________________

Email (*I the patient/guardian consent to receiving email communication/appt confirmation*):
____

☐ I have verified that my contact information is correct

SURGICAL PROCEDURES: (Including "Minor" Surgery or "Scopes"**)**

PROCEDURE	DATE	REASON	LOCATION/HOSPITAL

MEDICAL CONCERNS:

	YES	NO
RENAL FAILURE/DISEASE	☐	☐
DIALYSIS	☐	☐
DIABETES	☐	☐
INSULIN	☐	☐
METFORMIN	☐	☐
ACUTE KIDNEY INJURY	☐	☐
PACEMAKER	☐	☐
INSULIN/CHEMO PUMP	☐	☐
VASCULAR STENT	☐	☐
HEARING AID	☐	☐
OCCULAR IMPLANT	☐	☐
PENILE IMPLANT	☐	☐
TRANSDERMAL PATCHES	☐	☐
METAL FRAGMENTS IN EYES	☐	☐
DO YOU WORK WITH METAL?	☐	☐
PREGNANT?	☐	☐
HIGH BLOOD PRESSURE	☐	☐
COPD (athsma, emphysema, bronchitis)	☐	☐
ABNORMAL HEART RHYTHM	☐	☐

	YES	NO
DENTAL IMPLANTS	☐	☐
METAL RODS, PLATES, SCREWS:	☐	☐
LOCATION? ______________________		
PACEMAKER	☐	☐
PROSTHETIC HEART VALVE	☐	☐
CEREBRAL ANEURYSM CLIP	☐	☐
COCHLEAR (EAR) IMPLANTS	☐	☐
COILS, FILTERS, STENT	☐	☐
NEUROSTIMULATION SYSTEM	☐	☐
PROGRAMMABLE SHUNT (SPINAL)	☐	☐
SPINAL SURGERY	☐	☐
TISSUE EXPANDER	☐	☐
PROSTHESIS? (IE EYE)	☐	☐
PREVIOUS CHEMOTHERAPY	☐	☐
ALLERGY TO MRI/CT CONTRAST	☐	☐
CLAUSTROPHOBIA	☐	☐
HIGH CHOLESTEROL	☐	☐
HEART ATTACK	☐	☐
STROKE	☐	☐

Approx. Weight (required): ____________lbs **Approx. Height (required) ____________________**

SMOKING

Cigarettes YES ☐ NO ☐ How long (yrs)? ______________
Pack/Day__________ Age Started ________ Age Stopped _______

VAPE

Cigarettes YES ☐ NO ☐ How long (yrs)? ______________
Pack/Day__________ Age Started ________ Age Stopped _______

MARIJUANA

Cigarettes YES ☐ NO ☐ How long (yrs)? ______________
Pack/Day__________ Age Started ________ Age Stopped _______

NOTABLE FAMILY MEDICAL HISTORY:

____
____
____
____

ALCOHOL

Never/Occasional (less than 12oz per week or less than 12 beer per week) ☐
Often (greater than 12 oz per week or greater than 12 beer per week) ☐

DRUG ALLERGIES

YES ☐ NO ☐
If yes, which drugs? ____
How did you find out? ____
Reduction to allergy ____

CURRENT SYMPTOMS	YES	NO
COUGH	☐	☐
SHORTNESS OF BREATH	☐	☐
DIFFICULTY SWALLOWING	☐	☐
CHANGE OF VOICE (I.E. HOARSENESS)	☐	☐
LOSS OF APPETITE	☐	☐
LOSS OF ENERGY	☐	☐
SPUTUM	☐	☐
Color___________Blood______________		
LOSS OF WEIGHT	☐	☐
How much?____________Lbs		
ANY UNUSUAL PLACES OF TRAVEL?	☐	☐
Where and when? ____________________________		

IF WE ARE ABLE We will organize your tests & follow ups to be as close to home as possible. Please check the box to indicate which location is most convenient for you:

☐ Newmarket ☐ Orangeville ☐ Orillia ☐ Barrie ☐ Collingwood ☐ Markham
☐ Uxbridge ☐ Richmond Hill ☐ Huntsville ☐ Bracebridge ☐ Lindsay ☐ Midland

MEDICATION (do not fill out if you have a printed list**)**

NAME	DOSE & FREQUENCY	REASON

OTHER DRUGS (do not fill out if you have a printed list**)**

NAME	DOSE & FREQUENCY	REASON

OPIATES (do not fill out if you have a printed list**)**

NAME	DOSE & FREQUENCY	REASON