☐ Dr. David Dudok
☐ Dr. Robin Bruen
☐ Dr. Toby Chan

ADVANCED SURGICAL OPERATORY

230 Victoria Street
London, ON N6A 2C2
519-873-1700

PATIENT REGISTRATION FORM

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Phone: _____

E-mail: _____ Cell Phone: _____

Referring Doctor: _____ Family Doctor: _____

Next of Kin/Emergency Contact: _____ Phone: _____

OHIP # (include letters): _____ Expiry Date: _____ Occupation: _____

Preferred Pharmacy Name: _____ Pharmacy Phone: _____

HEALTH QUESTIONNAIRE (Check the box even if condition is controlled by medication)

Diabetes ☐No ☐Yes Year Diagnosed: _____ Controlled with: ☐Diet ☐Pills ☐Insulin

Within the past week what was your blood sugar: Low _____ High _____

High Blood Pressure ☐No ☐Yes **Heart Disease** ☐No ☐Yes

High Cholesterol ☐No ☐Yes **Past Stroke** ☐No ☐Yes

Skin Conditions ☐Rosacea ☐Psoriasis ☐Eczema **Thyroid Disease** ☐No ☐Yes (hyper or hypo)

Neurological ☐Migraine ☐Alzheimer's ☐Dementia **Respiratory** ☐Asthma ☐COPD

Family History: ☐Macular Degeneration ☐Glaucoma

Past Eye Surgery ☐No ☐Yes, specify: _____

Past Anaesthesia ☐No ☐Yes, specify any problems: _____

Drug Allergies ☐No ☐Yes, specify: _____

Latex Allergiy ☐No ☐Yes **Iodine Allergy** ☐No ☐Yes

MEDICATIONS (If taking multiple medications, you may want to have your pharmacist print out a list)

1._____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Have you **EVERY TAKEN** a drug called **Flomax (Tamsulosin)**? ☐No ☐Yes

Are you MRSA positive? ☐No ☐Yes ☐I don't know