Pre-Surgical Assessment Intake Form

Patient Information

Full Name

Date of Birth

Gender

Select...

Phone Number

Email Address

Address

Surgical Information

Planned Procedure

Scheduled Date

Consulting Surgeon

Medical History

Allergies

List any allergies, including medication, food, latex, etc.

Current Medications

List all current medications with dosages

Medical Conditions

List all chronic illnesses, previous surgeries, etc.

Lifestyle & Habits

Do you smoke?

Select...

Do you use alcohol?

Select...

Weight (kg)

Height (cm)

Additional Information

Other Relevant Details

Include any issues, concerns, or information you wish to share

Patient Signature

Date