



Medical History		
Current height and weight?	Height (cm)	Weight (kg)
Are you a current/past smoker? If yes, how many do you smoke a day? If past, when did you cease?	☐ Yes	☐ No
Do you drink alcohol? If yes, volume:	☐ Yes	☐ No
Are you Diabetic? If yes, please circle: TYPE 1 TYPE 2	☐ Yes	☐ No
Do you have a pace maker or internal defibrillator? Details:	☐ Yes	☐ No
Allergies: Details:	☐ Yes	☐ No
Previous medical/surgical history:		



Border Surgical Current Medication List

The medications that you are on may affect the outcome of any upcoming surgery.

Please complete this form so that your medications, including herbal medications, can be assessed. If required, you will be advised of medication you will need to cease prior to surgery. In some cases, an alternative medication will be organized.

**If you are not on any medications, please write NA.
Please ensure you sign and date this form.**

Name (please print): _____ **DOB:** ____/____/____

Signature: _____ **Date:** ____/____/____

MEDICATION NAME	DOSAGE