



**DR. MATHEW C. MOSHER INC.**  
Cosmetic, Plastic & Reconstructive Surgery

#301-8837 201<sup>st</sup> Street  
Langley, BC V2Y 0C8  
TEL: (604) 888-9378 FAX: (604) 888-9301

**Valley Surgery Centre**

PREADMISSION  
HISTORY & PHYSICAL FORM

**DATE OF SURGERY:**

Your patient is scheduled for elective surgery. The surgical facility and anesthesiologist require this History and Physical form to be completed. Although this patient has been thoroughly assessed by Dr. Mosher, your independent assessment is invaluable as this can uncover details of the patients' history that may not have been forthcoming during consultation. Optimal emotional and physical health is essential for patients considering elective surgery. If you have any concerns or questions, please contact me directly. ***The patient has been informed that MSP may not cover the cost of this examination.*** We have ordered new lab tests and ECG as necessary but any additional investigations you recommend should be ordered separately and results copied to Dr. Mosher. We apologize in advance if there is relatively little time before the surgery date to accommodate your patient but I encourage all patients to maintain a dialogue about this procedure with their primary care giver so that there is improved continuity of care. Thank you for your assistance.

**This form must be returned to Dr Mosher's Office (FAX: 604-888-9301) no later than:** \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**PERSONAL HEALTH #:** \_\_\_\_\_

**SURGICAL PROCEDURE:** \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**MEDICATIONS:** \_\_\_\_\_

**FUNCTIONAL CARDIAC ENQUIRY** \_\_\_\_\_  
RESP: \_\_\_\_\_  
OTHER: \_\_\_\_\_

**PAST ILLNESSES** ANESTHESIA: \_\_\_\_\_  
EXPERIENCE \_\_\_\_\_  
OTHER: \_\_\_\_\_

**FAMILY HISTORY** ANESTHESIA: \_\_\_\_\_  
PROBLEMS \_\_\_\_\_  
OTHER: \_\_\_\_\_

B/P \_\_\_\_\_ PULSE \_\_\_\_\_ RESP \_\_\_\_\_ WT \_\_\_\_\_ HT \_\_\_\_\_ BMI \_\_\_\_\_  
H & N: \_\_\_\_\_  
**PHYSICAL EXAM** HEART: \_\_\_\_\_  
LUNGS: \_\_\_\_\_  
ABDOMEN: \_\_\_\_\_  
SKELETAL: \_\_\_\_\_  
CNS: \_\_\_\_\_

DATE: \_\_\_\_\_ PHYSICIAN SIGNATURE: \_\_\_\_\_

PHYSICIAN NAME & BILLING # \_\_\_\_\_

ADDRESS: \_\_\_\_\_