Ohio Clinic® for Aesthetic and Plastic Surgery
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PATIENT REGISTRATION INFORMATION

DATE:______________________________
□DR. □ MR. □MS. □ MRS. □MISS

PATIENT NAME____

DATE OF BIRTH____________ **AGE**_______ **SS #:** ___________________________________ **MARITAL STATUS:** S M D W

ADDRESS ____

CITY ____ STATE _________ ________________________

WHAT IS THE BEST WAY TO CONTACT YOU? (PLEASE CHECK 2 OPTIONS, IF POSSIBLE)

□ **HOME PHONE**________________________ □ **BUSINESS PHONE**________________________ □ **CELL PHONE**__________________________

□ **E-MAIL ADDRESS**___________________________________ **(ALL INFORMATION IS PROTECTED BY HIPPA REGULATIONS)**

FAMILY PHYSICIAN_________________________________ **REFERRED BY** _________________________________

EMPLOYER ____

EMPLOYER ADDRESS ____

NAME OF EMERGENCY CONTACT:____

PHONE NUMBER:______________________________**RELATIONSHIP:**____________________________________

YOUR HEALTH IS: **EXCELLENT** ____ **GOOD** ____ **FAIR** ____ **POOR** ____

HEIGHT_____ **WEIGHT**______ ANY WEIGHT CHANGE IN THE PAST YEAR □**YES** □**NO** _____LBS LOST _____LBS GAINED

DRUG /FOOD ALLERGIES AND INTOLERENCES □**YES** □**NO** **IF YES, PLEASE LIST**
____
____

MEDICATION WITH DOSAGE (INCLUDING DIETARY AND HERBAL SUPPLEMENTS)_________________________________
____

WHAT ANTIBIOTICS HAVE YOU TAKEN BEFORE?___________________________

WHAT PAIN MEDICATIONS HAVE YOU TAKEN BEFORE, OTHER THAN OTC MEDS.______________________

DATE OF YOUR LAST PHYSICAL EXAM_______________ **EKG PERFORMED** □YES □NO **CHEST X-RAY** □ YES □NO

DO YOU HAVE: **HIGH BLOOD PRESSURE** □YES □ NO **DIABETES** □YES □ NO

HISTORY OF COLD SORES □YES □ NO

*****DO YOU TAKE ASPIRIN** YES NO **IF YES, HOW OFTEN**___________________________________

*****DO YOU SMOKE** YES NO **IF YES, HOW MUCH AND HOW OFTEN**____________________

Revised 08/12

OTHER MEDICAL ISSUES THE DOCTOR SHOULD BE AWARE OF ____
____

HAVE OTHER PLASTIC SURGEONS OR DOCTORS BEEN CONSULTED ☐YES ☐ NO

IF YES, OBJECTIVE OF CONSULT ____

PREVIOUS SURGERY (INCLUDE PLASTIC SURGERY) ____

____

ANY DIFFICULTY WITH ABOVE PROCEDURES ☐YES ☐NO

ANY DIFFICULTY WITH BLEEDING ☐YES ☐NO **AN DIFFICULTY WITH SCARRING** _☐YES ☐NO

DO YOU HAVE A HISTORY OF ANY EMOTIONAL DIFFICULTY ☐YES ☐NO. IF YES, PLEASE EXPLAIN: ____________________

____

DO YOU HAVE A HISTORY OF PSYCHIATRIC COUNSELING ☐ YES ☐ NO IF YES, PLEASE EXPLAIN______________________
____

NUMBER OF PREGNANCIES ______ **NUMBER OF CHILDREN** ______ **ARE YOU CURRENTLY PREGNANT** ☐YES ☐ NO

DO YOU PLAN ON ANY FUTURE PREGNANCIES ☐ YES ☐ NO

THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

____ ____________________________

PATIENT SIGNATURE **DATE**

BREAST SURGERY PATIENTS ONLY

DO YOU OR DOES YOUR FAMILY HAVE A HISTORY OF BREAST CANCER OR OTHER BREAST DISEASE? ☐ YES ☐NO
IF YES, PLEASE EXPLAIN.
____

DO YOU TAKE BIRTH CONTROL OR ANY TYPE OF HORMONE MEDICATION? ☐ YES ☐ NO IF YES, PLEASE LIST
MEDICATIONS____

HAVE YOU HAD ANY PREVIOUS SURGERY ON YOUR REPRODUCTIVE ORGANS? ☐ YES ☐NO IF YES, PLEASE EXPLAIN
____

HAVE YOU HAD PREVIOUS SURGERY ON BREASTS? ☐ YES ☐ NO IF YES, PLEASE LIST TYPE OF PROCEDURE(S)
____

ANY INJURY TO BREASTS? ☐ YES ☐NO IF YES, EXPLAIN____

DOES YOUR BREAST SIZE CHANGE WITH YOUR MENSTRUAL CYCLE OR WEIGHT FLUCTUATIONS? ☐YES ☐ NO

DID YOUR BREASTS CHANGE WITH PREGNANCY? ☐YES ☐NO HAVE YOU BREAST FED? ☐YES ☐NO

DO YOU PLAN TO BREAST-FEED IN THE FUTURE? ☐ YES ☐NO CURRENT BRA SIZE________________

WHEN AND WHERE WAS YOUR LAST MAMMOGRAM DONE?_______________________________
RESULTS : (PLEASE CHECK ONE) ☐NORMAL ☐ABNORMAL

INITIALS____________ DATE:___________

Revised 08/12