Ali Totonchi, M.D.

TOTONCHI
PLASTIC SURGERY

Patient Information Form

Division of Plastic Surgery
MetroHealth Medical Center

PLEASE PRINT

PATIENT NAME_____ BIRTH DATE____/____/____
LAST NAME FIRST NAME MIDDLE

PATIENT ADDRESS_____
STREET CITY STATE ZIP CODE

PHONE_____ AGE_____ MARITAL STATUS S___M___W___D___ SOCIAL SECURITY #_____-_____-_____

**EMAIL ADDRESS _____

EMERGENCY CONTACT_____RELATIONSHIP_____ PHONE_____

WHAT TYPE OF WORK DO YOU PERFORM?_____

EMPLOYER AND ADDRESS_____

COMPLAINT (REASON FOR SEEING US)_____

REFERRING PHYSICIAN_____ADDRESS_____

PRIMARY CARE PHYSICIAN_____ADDRESS_____

Circle the following answers and fill in requested information:

No Yes Do you smoke or use tobacco? How much?_____ How many years?_____
No Yes Do you use nicotine patches or gum?
No Yes Do you regulary drink alcohol or beer? How much?_____
No Yes Do you use marijuana or drugs?

Height _____ Weight _____

What medications do you take?_____

_____

List medication allergies. _____

_____

List any surgeries that you have had. _____

_____

List any medical problems. _____

_____

WOMEN ONLY THIS SECTION (Circle)
No Yes Have you had or have a blood relative with breast cancer?
No Yes Have you had a breast biopsy? When_____?
No Yes Have you had a mammogram within the last 2 years
Result_____.
No Yes Have you ever had a discharge from the nipples of your breasts?
No Yes Are you still having regular menstrual periods? Date of last menstrual period_____

PLEASE FILL OUT REVERSE SIDE

Do you have or have you had any of the following? Please circle and explain.

Skin: rash, ulcer, pigment changes, other_____

Eyes: glaucoma, cataracts, vision problems, eye pain, other_____

Ears, Nose, Throat: deafness, ringing in ears, deviated septum, sinus trouble, other_____

Lungs: cough, shortness of breath, asthma, emphysema, COPD, pneumonia, sleep apnea, other_____

Heart: chest pain, irregular heart beat, heart murmur, heart attack, pain or swelling of lower legs, varicose veins, dizziness, other _____

Have you had a stress test in the past? If yes, when was the test?_____

Gastrointestinal: nausea/vomiting, heartburn, acid reflux, abdominal pain, ulcer, gallbladder disease, liver disease, jaundice, rectal bleeding or blood in stool, diarrhea, other _____

Genitourinary: urinary trouble, blood in urine, prostate problems, kidney disease or failure, other_____

Musculoskeletal: back pain, spine problems, arthritis, muscle pain, joint pain, other_____

Neurological: headache/migraine, seizures, stroke, passing out, numbness or tingling, tremor, confusion, memory problems, paralysis, other _____

Psychiatric: mental illness, depression, anxiety, nervous breakdown, eating disorder, other_____

Blood/Lymph systems: anemia, excessive bleeding, easy bruising, Sickle cell disease or trait, swollen glands, bleeding gums, nosebleeds, other _____

Endocrine: thyroid problems, goiter, unwanted weight gain or loss, diabetes (sugar), excessive thirst, excessive urination, other_____

Are you presently taking any of the following medications? (Circle)

No Yes Aspirin
No Yes Blood pressure pills
No Yes Prednisone
No Yes Cough Medicine
No Yes Digitalis, Digoxin
No Yes Hormones
No Yes Insulin, Diabetic pills
No Yes Iron pills
No Yes Laxatives
No Yes Sleeping pills

No Yes Tranquilizers
No Yes Thyroid medicine
No Yes Arthritis medicine
No Yes Headache pills
No Yes Weight reducing pills
No Yes Water pills
No Yes Blood thinners
No Yes Dilantin
No Yes Barbiturates
No Yes Phenobarbital

No Yes Antibiotics
No Yes Birth control pills
No Yes Alka-seltzer
No Yes Sinus medicine
No Yes Other drugs not listed
_____

_____

OFFICE USE ONLY
Height_____ Weight_____ B.P._____ Pulse_____ Resp._____ Temp._____

_____

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