THE OTTAWA CLINIC
PLASTIC SURGERY
SKIN CARE & LASER CENTRE

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PATIENT INFORMATION STICKER

PATIENT INTAKE FORM

INFORMATION COLLECTED IN THIS FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF YOUR MEDICAL RECORD

First Name:		**Last Name:**	
Health Card Number:		**Expiry:**	
Address:			
City:	**Province:**	**Postal Code:**	
Date of Birth (DD/MM/YYY):		**Age:**	**Gender:**
Tel (H):	**Tel (W):**	**Tel (C):**	
Email:			
Preferred Pharmacy (please include location):			
Occupation:		**Hobbies:**	
Next of Kin:		**Tel:**	
Family Physician:		**Would you like your family physician notified of this appointment?** (please check if yes) ☐	
Referring Physician:			
How did you hear about The Ottawa Clinic?			
Reason for this visit:		**Would you prefer your confirmation in:** ☐ **English** ☐ **French**	

Past Surgical History: Please list all procedures you have had (including pediatric surgery, dental surgery, cosmetic surgery) and include any adverse reactions to surgery (i.e. bleeding, anaesthetic problems, malignant hyperthermia, etc.):

Surgery: _____ _____

_____ _____

_____ _____

Medications: Please list all prescription and non-prescription medications, vitamins and supplements (please include Aspirin and blood thinners):

_____ _____

_____ _____

_____ _____

Continued…

Allergies (medications, latex, surgical tape, etc):

Allergy: _____ **Reaction:** _____

_____ _____

_____ _____

Medical History: Please list your medical issues (including those for which you are being treated and/or followed):

_____ _____

_____ _____

_____ _____

In addition to above, please check and circle all that apply below (if any):

- ☐ Heart problems (heart attack, angina, irregular heart rhythm, high blood pressure, high cholesterol, heart valve replacement, pacemaker or defibrillator)
- ☐ Lung problems (breathing problems, asthma, emphysema, COPD, sleep apnea)
- ☐ Blood issues (bleeding tendencies, family history of bleeding, blood clot, embolism)
- ☐ Anxiety or emotional disorder
- ☐ Liver problems (hepatitis)
- ☐ Muscle/bone problems
- ☐ Poor healing or bad scars
- ☐ Cancer (including skin cancers)
- ☐ Digestive problem (heartburn)
- ☐ Kidney/bladder problems
- ☐ Thyroid problems
- ☐ HIV/AIDS
- ☐ Other: _____

Details: _____

_____

_____

Specific Health Questions:

Which is your dominant hand?	☐ Left	☐ Right	Tobacco use (packs per day): _____
Do you have sleep apnea?	☐ Yes	☐ No	How long: _____
If yes, do you use CPAP?	☐ Yes	☐ No	Ex. Smoker: _____
Do you have diabetes?	☐ Yes	☐ No	Cannabis use (frequency): _____
Treatment: _____			How long: _____
Do you have a latex allergy?	☐ Yes	☐ No	Alcohol use (drinks per day): _____
Do you require antibiotics prior to a surgical procedure?	☐ Yes	☐ No	How long: _____
Do you (or anyone in your family) have problems with anesthesia?	☐ Yes	☐ No	
Are you currently pregnant or trying to get pregnant?	☐ Yes	☐ No	

Please confirm the statements below:

☐ **I consent for photographs to be taken if deemed necessary. Photographs will only be used in your medical records.**

☐ **I declare that the statements made in this questionnaire are true to the best of my knowledge.**

Signature: _____ **Date:** _____