

1101 Bayside Drive , Newport Beach, CA 92625

Health Information as of _____ (enter today's date)
 (Please Print Legibly & Fill In or Correct All Fields)

Patient:				
DOB	Age	Marital Status	Weight	lbs
What surgery are you considering?			Height	ft in

DO YOU NOW OR HAVE YOU EVER HAD..... (You must circle an answer for each individual item)

Chicken Pox	Yes	No
Diphtheria	Yes	No
Scarlet Fever	Yes	No
Malaria	Yes	No
Measles	Yes	No
Rheumatic Fever	Yes	No
Typhoid Fever	Yes	No
Jaudice	Yes	No
Personal History of Cancer	Yes	No
Family History of cancer, heart trouble, stroke	Yes	No
Headaches	Yes	No
Dizziness	Yes	No
Tremors	Yes	No
Fainting	Yes	No
Loss of Equilibrium	Yes	No
Loss of Consciousness	Yes	No
Impaired Hearing	Yes	No
Visual Disturbances	Yes	No
Glaucoma or Eye Problems	Yes	No
Chronic Cough	Yes	No
Coughing or Spitting of Blood	Yes	No
Airway Obstruction (Nasal)	Yes	No
Sinus Infection	Yes	No
Postnasal Drip	Yes	No
Wheezing/Asthma	Yes	No
Night Sweats	Yes	No
Weight Loss	Yes	No
Lack of Appetite	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Difficulty Swallowing	Yes	No
Chronic Indigestion	Yes	No
Acid Reflux	Yes	No
Ulcer History	Yes	No
Hemorrhoids	Yes	No
Bleeding	Yes	No
Black Stool	Yes	No
Blood in Urine	Yes	No

Difficulty in Urination	Yes	No
Discharge	Yes	No
Vererneal Disease	Yes	No
Missed or irregular menstrual period	Yes	No
Nipple Discharge (Apart from Normal Lactaton)	Yes	No
Breast Cysts, Tumors, Abscesses	Yes	No
Heart Disease	Yes	No
Chest Pain	Yes	No
Heart Attack	Yes	No
Stroke	Yes	No
Hypertension (High Blood Pressure)	Yes	No
Blood Pressure Abnormalities	Yes	No
Abnormal EKG	Yes	No
Shortness of Breath	Yes	No
Palpitations	Yes	No
Irregular Heart Beats	Yes	No
Angina	Yes	No
Bleeding Tendencies	Yes	No
Pneumonia	Yes	No
Tuberculosis	Yes	No
Pleurisy	Yes	No
Diabetes	Yes	No
Arthritis	Yes	No
Nervous Breakdown	Yes	No
Depression	Yes	No
Seizures	Yes	No
Convulsions	Yes	No
Joint Disorder	Yes	No
Numbness	Yes	No
Paralysis	Yes	No
Pain	Yes	No
Hepatitis	Yes	No
Positive blood test for HIV, AIDS, Hepatitis	Yes	No
Anemia	Yes	No
Alcoholism or Drug Dependency	Yes	No
Drug Habit	Yes	No
Dentures, Bridges, Capped Teeth, or Crowns	Yes	No
Loose Teeth	Yes	No

If you have or had any of the above, please describe:

1. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Include over-the-counter medications.**

2. Do you have an allergic reaction to any medication? Yes No Which? _____

3. Do you react abnormally to any medication? Yes No Which? _____

4. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?
 Yes No If yes, when and where? _____

5. Have you ever been on cortisone or steroid treatment? Yes No When? _____

6. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?
 Yes No If so, how much? _____

7. Do you smoke? Yes No If so, how much? _____ For how long? _____

8. Are you pregnant? Yes No When was you last normal menstrual period? _____

9. How many pregnancies? _____ Births? _____ Breast Fed? Yes No How long? _____

10. When was your last physical exam? _____ By whom? _____

11. When was your last mammogram? _____ By whom? _____

12. When and where was your last chest x-ray? _____ EKG? _____

13. Who is your personal physician, if any? _____ Please list all physicians presently caring for you.

14. Have you ever been under psychiatric care? Yes No When? _____ Why? _____

15. Is there anything else you think the doctor should know? _____

16. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:

SURGICAL OPERATIONS (include where, when and why for each surgery): _____

HOSPITALIZATIONS (include where, when and why for each admission): _____

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____