BRIEF HISTORY

In an effort to serve, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Last Name: _______________ First___________________ Age_____ Sex: _____

Presenting Problem or Proposed surgery: _______________________________________

ILLNESS/INJURY: Please check if you ever had:

Yes No
___ ___ High blood pressure
___ ___ Diabetes
___ ___ Peptic Ulcers
___ ___ Heart attack
___ ___ Chest pain/tightness
___ ___ History of heart murmur
___ ___ Stroke
___ ___ Hepatitis
___ ___ Yellow jaundice

Yes No
___ ___ Kidney stone
___ ___ abdominal bleeding
___ ___ Diverticulitis
___ ___ Thyroid problem
___ ___ Lung problems/asthma
___ ___ Shortness of breath
___ ___ Cancer
___ ___ Gallstones
___ ___ Accidents/broken bones

List ____

FAMILY HISTORY: Please check if your family has history of

Yes No
___ ___ Breast Cancer
___ ___ Diabetes I or II
___ ___ Arteriosclerotic Cardiovascular disease
___ ___ Uterine Cancer
___ ___ Heart attack
__ _ ___ Crohn's Disease
___ ___ Ulcerative Colitis
___ ___ Sickle Cell Trait/Disease

Yes No
___ ___ Colon Cancer
___ ___ Melanoma
___ ___ Thyroid Cancer
___ ___ Coagulopathy
___ ___ CAD
___ ___ Sickle Cell Anemia

Operations: List names and dates of operation you had ☐ None

Year Name of Operation Type of anesthesia, if known Complications

____ ______________________ __________________________ ____________
____ ______________________ __________________________ ____________
____ ______________________ __________________________ ____________
____ ______________________ __________________________ ____________

Have you ever had a blood transfusion? ☐ Yes ☐ No

List any hospital admission or medical condition not listed above: ___________________

496 Old Newport Blvd., Suite 2., Newport Beach, CA 92663
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Females only: Are you pregnant? ☐ Yes ☐ No

MEDICATIONS: Please list all drugs you take and their dosage: ☐ None

Medication:	Dosage	Medication:	Dosage
_____________________	______	______________________	______
_____________________	______	______________________	______
_____________________	______	______________________	______
_____________________	______	______________________	______

ALLERGIES: Please list type and reaction

Name of Medication	Reaction
____________________	_______
____________________	_______
____________________	_______
____________________	_______

Do you smoke? ☐ Yes ☐ No Day # Yrs _____/_____

Have you ever smoked? ☐ Yes ☐ No Yrs quit __________

Do you drink alcohol? ☐ Yes ☐ No Day # Yrs ______/_____

Have you ever used drugs? ☐ Yes ☐ No Yrs quit _________

Type: _________________

Source of information, if other than patient: ____________________________________

_______________________________________ ______________________

Signature of patient (Parent if patient is minor) Date

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