MICHAEL J. WATANABE, M.D., APC **(949)859-8551**
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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)

Heart Trouble	Yes	No	Blood Disorders	Yes	No
Heart Attack	Yes	No	Bleeding Tendency (e.g. after tooth extraction)	Yes	No
Heart Pain	Yes	No			
Palpitation or Irregular Pulse	Yes	No	Hepatitis	Yes	No
Extra Heart Beats	Yes	No	Blood Tranfusions	Yes	No
Stroke	Yes	No			
Hypertension	Yes	No	Glaucoma or Eye Problems	Yes	No
Blood Pressure Abnormalities	Yes	No	Visual Disturbances	Yes	No
Abnormal EKG	Yes	No	Dry Eyes	Yes	No
Rheumatic Fever	Yes	No			
Heart Failure	Yes	No	Arthritis	Yes	No
Digitalis Treatment	Yes	No	Fracture of Neck or Spine	Yes	No
Heart Murmur	Yes	No			
			Palsy or Paralysis	Yes	No
Sleep Apnea	Yes	No	Seizures, Convulsions or Fainting spells	Yes	No
Shortness of Breath	Yes	No	Black Outs	Yes	No
Chest Pain	Yes	No			
Asthma	Yes	No	Missed or Irregular Menstrual Period	Yes	No
Bronchitis	Yes	No	Breast Cysts, Tumors, Abscesses	Yes	No
Pneumonia	Yes	No	Nipple Discharge (Apart from Normal Lactation)	Yes	No
Tuberculosis	Yes	No			
Smokers Cough	Yes	No	Dentures, Bridges, Capped Teeth or Crowns	Yes	No
Emphysema	Yes	No	Loose Teeth	Yes	No
Coughing or Spitting of Blood	Yes	No	Cosmetic Bonding to Teeth	Yes	No
Major Allergies	Yes	No	Piercing Other Than the Ears	Yes	No
Hay Fever	Yes	No			
Airway Obstruction	Yes	No	Self-Destructive Tendencies	Yes	No
			Psychiatric Hospitalization or Care	Yes	No
Problem Constipation	Yes	No	Nervous Breakdown	Yes	No
Vomiting Blood	Yes	No	Insomnia	Yes	No
Tarry or Bloody Bowel Movements	Yes	No	Drug Dependency	Yes	No
Ulcers	Yes	No	Alcoholism	Yes	No
Cirrhosis of the Liver	Yes	No			
			Family History of Cancer, Heart Trouble, Stroke	Yes	No
Kidney Disease	Yes	No	Family History with Bleeding Problems	Yes	No
			Family History with Anesthesia Problems	Yes	No
Diabetes	Yes	No			
Goiter or Thyroid Disease	Yes	No	Other Illnesses	Yes	No
			Explain:		
Skin Disorder	Yes	No			

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 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? _____

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

11. When was your last eye examination? _____ By whom? _____

12. When and where was your last mammogram? _____ EKG? _____

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

_____

14. Have you had any recent blood work done? ❒ Yes ❒ No Where? _____

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 and when for each surgery): _____

_____

_____

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

_____

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

Signature: _____ Date: _____