NEWPORT LAPAROSCOPY
Advanced Laparoscopic & General Surgery

ANDREW SAEED IRANIHA, M.D., F.A.C.S.
TEL: (949) 646-8388

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		Yes	No	
___	___	High blood pressure	___	___	Kidney stone
___	___	Diabetes	___	___	Abdominal bleeding
___	___	Peptic Ulcers	___	___	Diverticulosis
___	___	Heart attack	___	___	Thyroid problem
___	___	Chest pain/tightness	___	___	Lung problems/asthma
___	___	History of heart murmur	___	___	Shortness of breath
___	___	Stroke	___	___	Accidents/broken bones
					List _____
___	___	Cancer	___	___	Hepatitis
___	___	Yellow jaundice	___	___	Gallstones

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

Year	Name of Operation	Type of anesthesia, if known	Complications
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____

MAIN OFFICE:
496 Old Newport Blvd. Ste. 2
Newport Beach, CA 92663
TEL: **(949) 646-8388**
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IRVINE OFFICE:
16300 San Canyon Ave., Ste. 301
Irvine, CA 92618

BUENA PARK OFFICE:
5301 Beach Blvd., Ste. 101
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WEB:http://www.newportlaparoscopy.com
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Have you ever had a blood transfusion? ☐ Yes ☐ No
List any hospital admission or medical condition not listed above: _____

Females only: Are you pregnant? ☐ Yes ☐ No

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

Drug:	Dosage	Drug:	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES: Please list type and reaction

Name of Drug	Reaction	Name of drug	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you use tobacco? ☐ Yes ☐ No Day # Yrs _____/_____
Have you ever use tobacco? ☐ Yes ☐ No Yrs quit _____
Do you drink alcohol? ☐ Yes ☐ No Day # Yrs _____/_____
Have you ever used alcohol? ☐ 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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