



2507 EASTBLUFF DRIVE
NEWPORT BEACH, CA 92660
PH (949) 200-1655 F (949) 200-1656

HEALTH QUESTIONNAIRE

Patient Name (Last, First): _____ Date: _____

Patient Date of Birth: _____ Reason for Visit: _____

For office use only:
Vitals: Wt: _____ Ht: _____

Medical History (Please check all that apply):

Chicken Pox _____ Cancer _____ Hypertension _____ Seizure _____ Asthma _____
Diabetes _____ Anemia _____ Heart Disease _____ HIV _____ COPD _____
Stroke _____
Other _____

Past Surgeries (Please check all that apply):

Gall Bladder _____ Appendix _____ Hysterectomy _____ Heart _____ Lung _____
Other _____

Please list all allergies:

None _____ Unknown _____

Please list all medications you are currently taking:

None _____

Family History (Please check all that apply):

Cancer _____ Diabetes _____ Heart Disease _____ Other _____

Alcohol/Tobacco (Please check all that apply):

Tobacco _____
Alcohol Use _____
Frequency: _____

Tetanus:

_____ less than 5 years
_____ more than 5 years