New Patient Questionnaire

Newport Beach Medical Associates
361 Hospital Road, Ste. 322
Newport Beach, CA 92663
949 – 574 -0777

Name: _____ Date: _____

Birthdate: _____ Previous Primary Physician: _____

Reason for today's visit: _____ Current Specialists: _____

_____

_____

Medications

Please list any medications with strength that you currently take regularly (including non-prescription)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies

Please list any allergies to the following: medications, foods or other

_____

_____

_____

Medical History

Illnesses/Conditions

Do you have or have you ever had any of the following:

		Year
_____	Anemia	_____
_____	Anethesia complications	_____
_____	Anxiety	_____
_____	Arthritis	_____
_____	Asthma	_____
_____	Birth Defects	_____
_____	Cancer (type: _____)	_____
_____	Colitis	_____
_____	Concussion	_____
_____	Depression/Nervous Breakdown	_____
_____	Diabetes	_____
_____	Emphysema	_____
_____	Heart Attack/Heart Disease	_____
_____	High Blood Pressure	_____
_____	High Cholesterol	_____
_____	Kidney Disease	_____
_____	Liver Disease/Hepatitis	_____
_____	Migraine Headaches	_____
_____	Mitral Valve Prolapse/Murmur	_____
_____	Osteoporosis	_____
_____	Pneumonia	_____
_____	Rheumatic Fever	_____
_____	Seizure Disorder	_____
_____	Sexually Transmitted Disease	_____
_____	Stroke	_____
_____	Thyroid Disorder	_____
_____	Tuberculosis	_____
_____	Ulcer	_____

Surgical Procedures/Hospitalizations	**Year**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Childhood Diseases		**Year**
_____	Chickenpox	_____
_____	Measles	_____
_____	Mumps	_____
_____	Polio	_____
_____	Other: _____	_____

Gynecological History (women only)

Last menstrual period	_____
How many pregnancies have you had?	_____
How many children do you have?	_____
Have you ever had an abnormal pap?	_____
Have you had a hysterectomy?	_____
Have your ovaries been removed?	_____

Continued on other side →

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Health Maintenance continued

Name: _____
Birthdate: _____

Family History

Has any blood relative ever had any of the following :

	Relative (mother, father, sister, etc.)
Alcoholism	
Asthma	
Bleeding problems	
Cancer	
Type:	
Diabetes	
Emphysema	
Glaucoma	
Heart Attack	
Heart Disease	
High Blood Pressure	
Mental Illness / Suicide	
Osteoporosis	
Seizures	
Stroke	
Thyroid	

	Living Age	Deceased Age (at death) & cause
Father		
Mother		
Brother		
Sister		
Son		
Daughter		

Health Maintenance

When, if ever, did you last have any of the following:

_____ Cholesterol check
_____ Colonoscopy
_____ EKG/Cardiogram
_____ Mammogram
_____ Pap Smear
_____ Prostate exam
_____ Cardiac stress test
_____ Bone Density

List Year of Last Vaccinations:

_____ Tetanus (TD)
_____ Influenza (Flu)
_____ Pneumonia
_____ Hepatitis A
_____ Hepatitis B
_____ TB Skin Test
_____ Shingles (Zostavax)

Social History

Marital Status? *Circle One* *Single* *Married* *Divorced* *Widow* *Partner*
Do you have children / dependents at home? **Yes / No** *How many?* _____
Are you employed? **Yes / No** *What field?* _____
Do you or have you ever smoked or chewed tobbacco? **Yes / No** *When?* _____ *Quit date?* _____
Packs/cans/bags per day _____ */ yrs* _____ *Type?* _____ *How often?* _____
Do you or have you ever used illegal drugs? **Yes / No** *Type?* _____ *How often?* _____
Do you drink alcohol? **Yes / No** *Type?* _____ *How often?* _____
Have you been exposed to toxic substances? **Yes / No**
Do you drink caffeine daily? **Yes / No** *Type?* _____ *How often?* _____
Do you exercise regularly? **Yes / No** *Type?* _____ *How often?* _____
Do you wear seat belts? **Yes / No**
Do you use car seats for your children if under 60lbs.? **Yes / No**
Do you have a living will or advance directives? **Yes / No**
What is your highest level of education? _____