

Place Label Here

Name: \_\_\_\_\_

DOB: \_\_\_\_\_



**Stanford**  
HEALTH CARE

# Health Questionnaire

*Please arrive 30 minutes prior to your appointment*

|   |             |      |  |                                |
|---|-------------|------|--|--------------------------------|
| Last Name:  | First Name: | DOB: | <input type="checkbox"/> F<br><input type="checkbox"/> M | <input type="checkbox"/> Other |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed |             |      | Occupation:  |                                |
| Previous or Referring Doctor:   |             |      | Date of last physical exam:                              |                                |

**Medications: Please bring all prescription medications you are currently taking**

| Name | Dose and Directions | Reason |
|------|---------------------|--------|
|      |                     |        |
|      |                     |        |
|      |                     |        |
|      |                     |        |
|      |                     |        |

**Allergies and Reactions:** \_\_\_\_\_

**Do you currently have, or have ever had, any of the following illnesses or conditions?**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Abnormal Pap          | <input type="checkbox"/> Gallbladder Disease     | <input type="checkbox"/> Osteoporosis                 |
| <input type="checkbox"/> Alcohol/Drug Problem  | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Other Injuries               |
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Gout                    | <input type="checkbox"/> Peripheral Artery Disease    |
| <input type="checkbox"/> Anxiety/Depression    | <input type="checkbox"/> Hay Fever               | <input type="checkbox"/> Pneumonia                    |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Head Injury             | <input type="checkbox"/> Positive TB Test             |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> Prostate Problem             |
| <input type="checkbox"/> Atrial Fibrillation   | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Psychiatric-Depression       |
| <input type="checkbox"/> Blood Clots           | <input type="checkbox"/> Heart murmur            | <input type="checkbox"/> Psychiatric-Other            |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Rheumatic Fever              |
| <input type="checkbox"/> Chicken Pox           | <input type="checkbox"/> Hernia                  | <input type="checkbox"/> Seizures                     |
| <input type="checkbox"/> Chronic Lung Disease  | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Colon/Bowel Disease   | <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Sleep Apnea                  |
| <input type="checkbox"/> Dementia              | <input type="checkbox"/> Infection of the uterus | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Diabetes Type I or II | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Thyroid Disease              |
| <input type="checkbox"/> Diverticulitis        | <input type="checkbox"/> Migraines               | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Emphysema             | <input type="checkbox"/> Neuropathy              | <input type="checkbox"/> Ulcer                        |

**Surgical and Hospitalization History (include dates)**

|  |  |
|--|--|
|  |  |
|  |  |
|  |  |
|  |  |

| Family History<br><i>(Use back of page if needed)</i> |  | Age                             | Medical conditions<br>Indicate <b>Healthy</b> -or- diabetes, high blood pressure, cholesterol, heart disease, stroke, cancer (type) |   |
|---|--|---------------------------------|---|---|
| Mother  | <input type="checkbox"/> Living <input type="checkbox"/> Deceased  |                                 |   |   |
| Father  | <input type="checkbox"/> Living <input type="checkbox"/> Deceased  |                                 |   |   |
| Sibling   | <input type="checkbox"/> F<br><input type="checkbox"/> M<br><input type="checkbox"/> Living<br><input type="checkbox"/> Deceased |                                 |   |   |
| Sibling   | <input type="checkbox"/> F<br><input type="checkbox"/> M<br><input type="checkbox"/> Living<br><input type="checkbox"/> Deceased |                                 |   |   |
| Sibling   | <input type="checkbox"/> F<br><input type="checkbox"/> M<br><input type="checkbox"/> Living<br><input type="checkbox"/> Deceased |                                 |   |   |
| Sibling   | <input type="checkbox"/> F<br><input type="checkbox"/> M<br><input type="checkbox"/> Living<br><input type="checkbox"/> Deceased |                                 |   |   |
| Grandmother<br>Mother's Side                          | <input type="checkbox"/> Living<br><input type="checkbox"/> Deceased   |                                 |   |   |
| Grandfather<br>Mother's Side                          | <input type="checkbox"/> Living<br><input type="checkbox"/> Deceased   |                                 |   |   |
| Grandmother<br>Father's Side                          | <input type="checkbox"/> Living<br><input type="checkbox"/> Deceased   |                                 |   |   |
| Grandfather<br>Father's Side                          | <input type="checkbox"/> Living<br><input type="checkbox"/> Deceased   |                                 |   |   |
| Children  | <input type="checkbox"/> F<br><input type="checkbox"/> M<br><input type="checkbox"/> Living<br><input type="checkbox"/> Deceased |                                 |   |   |
| Children  | <input type="checkbox"/> F<br><input type="checkbox"/> M<br><input type="checkbox"/> Living<br><input type="checkbox"/> Deceased |                                 |   |   |
| Extended Family Members                               |  | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart attacks  | <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes |

| Patient History      |  |
|----------------------|--|
| <b>Smoking</b>       | <b>Cigarette Use:</b> <input type="checkbox"/> Never<br><input type="checkbox"/> Former Smoker      Date quit or age: _____<br><input type="checkbox"/> Current Smoker   |
|                      | <b>Other tobacco use:</b> <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars <input type="checkbox"/> Chewing Tobacco   |
|                      | <b>Other:</b> <input type="checkbox"/> e-Cigarettes <input type="checkbox"/> Marijuana   |
| <b>Alcohol</b>       | <b>Do you drink alcohol?</b> <input type="checkbox"/> Yes <input type="checkbox"/> 0-1 times/month <input type="checkbox"/> 2-4 times/month <input type="checkbox"/> Every week<br><input type="checkbox"/> No |
|                      | Each week, how many: _____ Servings of beer? _____ Glasses of wine? _____ Shots/mixed drinks? _____  |
|                      | When did you last have more than 4 drinks in one day? _____  |
|                      | Do you feel you should cut down on your drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No   |
|                      | Do people annoy you by nagging about your drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No   |
|                      | Have you ever felt guilty about drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| <b>Drugs</b>         | Have you used recreational or street drugs within the last two years? <input type="checkbox"/> Yes <input type="checkbox"/> No   |
|                      | Have you ever used recreational drugs with a needle? <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| <b>Sexual Health</b> | <input type="checkbox"/> Sexually active <input type="checkbox"/> Not currently sexually active <input type="checkbox"/> Never sexually active   |
|                      | Sexual Partners: <input type="checkbox"/> Men <input type="checkbox"/> Women      # of Partners in last year: _____  |
|                      | History of Sexually Transmitted infections? If yes, type/dates: _____  |
|                      | Current contraception method: _____ Previous methods: _____  |
|                      | <b>Women:</b> # of children: _____ # of pregnancies: _____ # of miscarriages: _____ # of abortions: _____<br>Date of last menstrual period: _____  |

|   |   |
|---|---|
| <b>Personal Safety</b>  | Do you wear a seatbelt? <input type="checkbox"/> Yes <input type="checkbox"/> No  |
|   | <b>Have you fallen in the last year?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | If yes, how many times? _____ Any injuries? _____   |
|   | <b>Do you feel unsteady when standing or walking?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  |
|   | <b>Do you worry about falling?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | Does your house have a working smoke detector? <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Does a partner, or anyone at home, hurt, hit, or threaten you, or take advantage of you financially? <input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| <b>Patient Health</b>   | <b>Over the last two weeks, how often have you been bothered by any of the following problems?</b>  |
|   | <b>Little interest or pleasure in doing things</b><br><input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than Half of the Days <input type="checkbox"/> Nearly Every Day |
|   | <b>Feeling down, depressed, or hopeless</b><br><input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than Half of the Days <input type="checkbox"/> Nearly Every Day        |
| <b>Exercise</b>   | <input type="checkbox"/> Sedentary (No exercise)  |
|   | <input type="checkbox"/> Mild Exercise (i.e., climb stairs, walk three blocks, golf)  |
|   | <input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation 1-3x week for 30 minutes)   |
|   | <input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation > 3x/week for 30 minutes)  |

| Immunizations  | Date | Immunization   | Date |
|--|------|--|------|
| <input type="checkbox"/> Flu Vaccine                   |      | <input type="checkbox"/> TD (Tetanus Shot)   |      |
| <input type="checkbox"/> TDAP (Whooping Cough/Tetanus) |      | <input type="checkbox"/> Zostavax (Shingles)<br><input type="checkbox"/> Shingrix (Shingles) |      |
| <input type="checkbox"/> Pneumococcal PCV13            |      | <input type="checkbox"/> HPV   |      |
| <input type="checkbox"/> Pneumococcal PPV23            |      | <input type="checkbox"/> Meningococcal ACWY  |      |
| <input type="checkbox"/> Hepatitis A                   |      | <input type="checkbox"/> Meningococcal B   |      |
| <input type="checkbox"/> Hepatitis B                   |      | <input type="checkbox"/> Other:  |      |

**Please list the names of the physicians and specialists you have seen:**

|                         |  |              |  |
|-------------------------|--|--------------|--|
| Previous Primary Care   |  | Gynecologist |  |
| Gastroenterologist (GI) |  | Urologist    |  |
| Cardiologist            |  | Eye doctor   |  |
| Other                   |  | Other        |  |

**Preventative Screenings:** To avoid duplication and to provide you with the best care possible, we would like the information on the following items and to obtain a copy of your most recent reports. **Either bring us a copy or let us know from where we can request a copy. (Not all ages and genders will need to provide the information listed below.)**

| Item                   | Date last performed | Result (if applicable) | Comments |
|------------------------|---------------------|------------------------|----------|
| Aortic Aneurysm Screen |                     |                        |          |
| Bone Density Test      |                     |                        |          |
| Cholesterol Test       |                     |                        |          |
| Colonoscopy            |                     |                        |          |
| Dental Exam            |                     |                        |          |
| Eye Exam               |                     |                        |          |
| Hepatitis C Test       |                     |                        |          |
| HIV Test               |                     |                        |          |
| HPV Test               |                     |                        |          |
| Mammogram              |                     |                        |          |
| Pap Smear              |                     |                        |          |
| Prostate Exam          |                     |                        |          |
| Stool Test for Blood   |                     |                        |          |

*Additional Comments: (use back of page if needed)*