NEW PATIENT QUESTIONNAIRE-ADULT

Name: ______________________

Legal Name if different: ______________________

Please place Label Here

Pronouns (optional): ______________________

Date Of Birth: ______________________

Reason For Visit Today

____

____

Preferred Pharmacy

______________________________ Address: ______________________

Current Medications- Including OVER THE COUNTER medications

Name	Dose & Direction	Reason For Medication

Allergies and Reactions

Allergen	Type Of Reaction

Are You Currently In Any Pain?

☐ No ☐ Yes

If yes,on a scale from one to ten, how intense is the pain? ______________

If yes, where is the pain located?

____

____

Stanford HEALTH CARE
STANFORD MEDICINE

NEW PATIENT QUESTIONNAIRE-ADULT

Check all that applies to past and present medical conditions

☐	Alcohol/Drug Issue	☐	Diabetes	☐	Osteoporosis
☐	Anemia	☐	Emphysema	☐	Positive TB Test
☐	Anxiety	☐	Gender Dysphoria	☐	Prostate Issue
☐	Arthritis	☐	Heart Disease	☐	Seizure Disorder
☐	Asthma	☐	Heart Failure	☐	STI
☐	Atrial Fibrillation	☐	Hepatitis	☐	Sleep Apnea
☐	Blood Clots	☐	High Blood Pressure	☐	Stomach Ulcers
☐	Cancer	☐	High Cholesterol	☐	Stroke
☐	Dementia	☐	Kidney Disease	☐	Thyroid Disease
☐	Depression	☐	Liver Disease		

Family Health History

Family Member	Living (L) Deceased (D)* Unknown (U)	Medical Conditions Please specify Premature Heart Disease, Diabetes Cancer of any type, Prostate/breast/Ovarian Problems
Mother		
Father		
Mothers Mom		
Mothers Dad		
Fathers Mom		
Fathers Dad		
Sister		
Brother		
*** If deceased, please indicate age.		

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NEW PATIENT QUESTIONNAIRE-ADULT

Name: ______________________

Please place Label Here

Surgical History (Check All that Apply)

- [ ] Appendectomy
- [ ] Cardiac Angioplasty, Stent or Bypass
- [ ] Cardiac Catheterization
- [ ] Cesarean Section
- [ ] Gall Bladder-Laparoscopic
- [ ] Gall Bladder-Open
- [ ] Gender Affirming Surgery
- [ ] Hernia Repair
- [ ] Hysterectomy-Partial
- [ ] Prostate Surgery

Other Medical and Surgical History

____
____
____
____
____

Tobacco Use

Type of Tobacco: ______________________________

Status: [ ] Never [ ] Previous [ ] Current

Start Date: __________ Years: __________

Quit Date: __________ Packs or Amount/ Day: __________

If you would like information on quiting assistance, please consult your Physician.

Alcohol Use

[ ] Never [ ] Occasional [ ] Frequently

If you have marked yes to Alcohol use, on a weekly basis , please answer the following:

[ ] # of 12oz Beer [ ] # of 6oz Wine [ ] # of 0.5oz Drinks

Drug Use

[ ] No [ ] Yes

If yes, please discuss with the Physician.

"This form is not to be scanned as part of the patient chart."