Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HEALTH CARE
STANFORD, CALIFORNIA 94305

CLINIC ● MULTISPECIALTY ● NEW PATIENT QUESTIONNAIRE

CURRENT MEDICAL PROBLEMS

Please list in order of importance to you.

______________________ How long ______________

______________________ How long ______________

______________________ How long ______________

______________________ How long ______________

PAST MEDICAL HISTORY

❑ Allergies	❑ Blood clots	❑ Gallbladder disease	❑ Heart Attack
❑ Anemia	❑ Cancer	❑ Gastroesophageal reflux disease (GERD)	❑ Osteoarthritis
❑ Angina	❑ Cerebrovascular accident	❑ Hepatitis C	❑ Osteoporosis
❑ Anxiety	❑ Chronic obstructive pulmonary disease (COPD)	❑ Hyperlipidemia	❑ Peptic ulcer disease
❑ Arthritis	❑ Coronary artery disease	❑ Hypertension	❑ Renal disease
❑ Asthma	❑ Crohn's disease	❑ Irritable bowel disease	❑ Seizure disorder
❑ Atrial Fibrillation	❑ Depression	❑ Liver disease	❑ Stroke
❑ Benign prostatic hypertrophy	❑ Diabetes	❑ Migraine headaches	❑ Thyroid disease
❑ Other: ______________			

PAST SURGICAL HISTORY- Please write in year

General Surgery			
	Year		**Year**
Angioplasty		Hip replacement	
Angioplasty w/ stent		Knee replacement	
Appendectomy		Laser-assisted in situ keratomileusis (LASIK)	
Arthroscopy knee		Liver biopsy	
Back surgery		Open reduction internal fixation	
Coronary artery bypass graft		Pacemaker	
Carpal tunnel release		Small bowel resection	
Cataract extraction		Thyroidectomy	
Cholecystectomy		Tonsillectomy	
Colectomy		Other:	
Colostomy			
Gastric bypass			
Hernia repair			

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For Males:	
	Year
Prostate biopsy	
Transurethral resection of the prostate (TURP)	
Vasectomy	

For Females:					
	Year		Year		Year
Augmentation mammoplasty		Pregnancy termination		Breast reduction	
Bilateral tubal ligation		Hysterectomy		Total hysterectomy/ Ovary removal	
Breast biopsy		Mastectomy		Vaginal hysterectomy	
Cesarean section		Myomectomy		Other:	

Please list the physicians you have seen in the past three years and why:

____

____

____

When was your last physical exam and with whom:

____

FAMILY HISTORY

Member	Age	Illnesses, if any	If Deceased, at what age	Cause of death
Mother				
Father				
Sister				
Brother				
Maternal Aunt				
Maternal Uncle				
Paternal Aunt				
Paternal Uncle				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Daughter				
Son				
Other: ________________				

SOCIAL HISTORY

Birthplace ______________________ How long in California? ______________________

Education - last year of school completed? ______________________

Tobacco Use: Yes No Quit ______________(date) If yes, packs per day? ______ For how many years? ______	**Alcohol Use:** Yes No If no, did you previously drink regularly? Yes No
Second hand smoke exposure: Yes No	**Caffeine beverages:** Yes No Coffee______ Tea______ Sodas______
Exercise: Yes No Type ____________ Frequency ____________ Duration ______________________	**Hobbies and activities:** ______________________
Do you use a seat belt when driving and when a passenger? Yes No	**Would you allow a blood transfusion if your physician considered it necessary?** Yes No
Do you have an Advanced Directive in place? Yes No	**To whom can we talk to about your medical care?** ______________________
In the case of a medical emergency please contact: **Name:** ______________________ **Phone Number:** ______________________	**At what phone number, can we leave you a confidential voice mail message?** ______________________

Please list all **current medications** (prescription, over the counter, herbal, recreational).
Give dosage and frequency.

Medication Names	Dosage	How Often Taken?

Please list any medication or adverse reactions:

Medication Allergies (include tape, latex, etc.)	Reaction	Comments

Immunizations: Have you had these vaccinations? If so, when (dates) and where (location)?

	Location	Date		Location	Date
Hepatitis A			Polio Injection or oral		
Hepatitis B			Tetanus		
HPV (Gardasil)			Typhoid		
Influenza			Varicella		
Measles, Mumps, Rubella			Yellow Fever		
Meningitis			Zoster (Shingles)		
Pneumonia			Other:		

Health Maintenance:

	Date:	Where was it performed:
Last pap		
Last mammogram		
Last colonoscopy		
Last bone density scan		

DATE ______ TIME ______ SIGNATURE (Patient /Legal Designated Representative) ______

PRINT NAME ______ RELATIONSHIP TO PATIENT ______

DATE ______ TIME ______ PHYSICIAN SIGNATURE ______ PRINT NAME ______