Medical Record Number

Patient Name

Addressograph Stamp or Label - Patient Name, Medical Record Number

STANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305

CLINICS • ORTHOPAEDIC SURGERY • NEW PATIENT QUESTIONNAIRE

These questions are general screening questions designed to identify areas where additional attention may be required. Thank you.

Date Completed: _____ Name of Person Completing Form: _____

Patient Name: _____ Weight: _____ Height: _____ Age: _____

Primary Care Physician: _____

Current Occupation: _____

Reason for today's visit: _____

PAST MEDICAL HISTORY

Circle YES or NO for any significant conditions that apply.

Anemia	YES	NO	Hay Fever/Sinus Problems	YES	NO
Asthma/Bronchitis/Emphysema	YES	NO	Heart Problems	YES	NO
Arthritis	YES	NO	Hepatitis	YES	NO
Bleeding/Bruising/Blood Disorder	YES	NO	High Blood Pressure	YES	NO
Cancer (type) _____	YES	NO	Immune Disorder	YES	NO
Depression	YES	NO	Kidney Disorder	YES	NO
Diabetes			Liver Disease	YES	NO
Insulin Injection Dependent	YES	NO	Stroke	YES	NO
Non-Insulin Dependent	YES	NO	Thyroid Disease	YES	NO
Drug Abuse/Alcohol Dependency	YES	NO	Tuberculosis (TB)	YES	NO
Epilepsy/Seizures	YES	NO	Stomach Ulcers	YES	NO

Other (describe) _____

List previous hospitalizations, major surgeries, serious injuries and approximate dates:

Medications - List all medications you are taking and dosages (prescription and all over-the-counter drugs):

Allergies - List medication, food, latex and environmental allergies and describe reaction(s):

Have you had significant exposure to: Pesticides? ❑ YES ❑ NO Toxic waste? ❑ YES ❑NO

Have you had previous treatment with or exposure to radiation? ❑ YES ❑ NO

If YES, explain: _____

FAMILY HISTORY

List health problems in your family:

	Age	Medical Problems	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			
Grand-parents			

SOCIAL HISTORY

Tobacco use: ❑ YES ❑ NO

Cigarettes: Pack(s) per day: _____ How many years: _____ If you quit, when? _____

Other tobacco use: Amount per day: _____ How many years: _____ If you quit, when? _____

Alcohol use: ❑ NO ❑ YES If yes, how often and how much? _____

Do you use any drugs other than prescribed or over the counter medication? ❑ NO ❑ YES

If yes, please list: _____

Do you eat a balanced diet? ❑ YES ❑ NO Is your weight stable? ❑ YES ❑ NO

Indicate any other important information the doctor should know: _____

_____

_____

Birthplace: _____

_____

Marital status/Relationship: _____

Who currently lives at home with you? _____

EXTENDED REVIEW OF SYSTEMS

Do you presently have any problems or symptoms in for following areas?
If "YES", give an explanation.

	Yes	No	Patient Explanation:	Provider Comments:
Constitutional				
good health	Y	N		
recent weight changes	Y	N		
recurrent fevers, chills, sweats	Y	N		
fatigue	Y	N		
Eyes				
wear glasses/contact lenses	Y	N		
blurred or double vision	Y	N		
change in vision	Y	N		
glaucoma	Y	N		
Ears/Nose/Mouth/Throat				
change in hearing	Y	N		
ringing in the ears	Y	N		
recent nose bleeds	Y	N		
chronic sinus problems	Y	N		
mouth sores	Y	N		
frequent sore throats	Y	N		
voice changes	Y	N		
Respiratory				
asthma or wheezing	Y	N		
breathing problems	Y	N		
coughing up blood	Y	N		
chronic cough	Y	N		
pneumonia	Y	N		
Cardiovascular				
heart trouble or heart attack	Y	N		
chest pain or angina	Y	N		
shortness of breath	Y	N		
palpitations	Y	N		
swelling of feet, ankles or hands	Y	N		
blood clots	Y	N		
varicose veins	Y	N		
Gastrointestinal				
change in appetite	Y	N		
severe heartburn	Y	N		
bleeding ulcers	Y	N		
frequent nausea/vomiting	Y	N		
vomiting blood	Y	N		
frequent diarrhea	Y	N		
constipation/painful bowel movements	Y	N		
black or bloody stools	Y	N		
rectal bleeding	Y	N		
abdominal pain	Y	N		
Genitourinary				
blood in urine	Y	N		
burning with urination	Y	N		
change in force of stream when urinating	Y	N		

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	Yes	No	Patient Explanation:	Provider Comments:
Genitourinary (continued)				
sexually transmitted disease	Y	N		
change in sexual function or interest	Y	N		
Men:				
prostate trouble	Y	N		
scrotal masses	Y	N		
Women:				
pain/problems with periods	Y	N		
abnormal uterine bleeding	Y	N		
uterine tumors	Y	N		
Neurological				
headaches	Y	N		
numbness or tingling sensations	Y	N		
weakness or paralysis	Y	N		
convulsions or seizures	Y	N		
change in memory or concentration	Y	N		
Integumentary (Skin and Breasts)				
birth marks	Y	N		
recurrent rashes	Y	N		
changing moles	Y	N		
skin cancer or melanoma	Y	N		
non-healing wounds	Y	N		
change in hair or nails	Y	N		
breast pain or lump	Y	N		
Psychiatric				
memory loss or confusion	Y	N		
nervousness	Y	N		
depression	Y	N		
change in sleep	Y	N		
Musculoskeletal				
joint stiffness or pain	Y	N		
muscle pain or cramping	Y	N		
weakness of muscles or joints	Y	N		
difficulty walking	Y	N		
back pain	Y	N		
Endocrine				
heat or cold intolerance	Y	N		
excess thirst or urination	Y	N		
thyroid problems	Y	N		
Allergic/Immunologic				
low resistance to infection	Y	N		
recent cold or flu	Y	N		
environmental allergies	Y	N		
reaction to medication(s)	Y	N		
tetanus booster within past 10 years	Y	N		
other immunizations up to date	Y	N		
Hematologic/Lymphatic				
easy bruising	Y	N		
frequent bleeding	Y	N		
enlarged lymph nodes	Y	N		

Signature of Person Completing this Form

Relationship (if other than Patient)

PROVIDER DOCUMENTATION

Instructions to Attending Physician:

Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key finding(s) with the patient and/or family. Key finding(s) must be summarized in you progress note, however the questionnaire may be referenced for additional details.

Attending Physician Signature _____ Date _____

The preceding information was also reviewed by:

Provider Signature/Title _____ Date _____

Provider Signature/Title _____ Date _____

Provider Signature/Title _____ Date _____