Stanford HEALTH CARE
STANFORD MEDICINE

Patient Label

Name____________________________________ Date of Birth_______________ Date________________

CURRENT CONCERNS. Please list in the order of importance to you.

____ How long____________________
____ How long____________________
____ How long____________________
____ How long____________________

PAST MEDICAL HISTORY + YEAR DIAGNOSED:

__Allergies
__Anemia
__Angina
__Anxiety
__Arthritis
__Asthma
__Atrial Fib
__Benign prostatic Hypertrophy
__Blood clots
__Cancer
Type:
Yr Diagnosed:
Doctor:
__Stroke
__COPD
__Coronary artery disease
__Crohn's disease/Ulcerative colitis
__Depression
__Diabetes
__Gallbladder disease
__GERD/Heartburn
__Hepatitis C
__Hyperlipidemia
__Hypertension
__Irritable bowel disease
__Liver disease
__Migraine headaches
__Heart Attack
__Osteoarthritis
__Osteoporosis
__Peptic ulcer disease
__Renal Disease
__Seizure disorder
__Thyroid disease
Other:

PAST SURGICAL HISTORY - please write in year

__Angioplasty
__Angio w/ stent
__Appendectomy
__Athroscopy Knee
__Back Surgery
__Coronary artery bypass graft
__Carpal tunnel release
__Cataract extraction
__Gallbladder surgery
__Colostomy
__Gastric Bypass
__Hernia Repair
__Hip Replacement
__Knee replacement
__LASIK
__Liver biopsy
__Open reduct internal fixation
__Pacemaker
__Small bowel resection
__Thyroidectomy
__Tonsillectomy

For Males:

__Prostate biopsy
__TURP
__Vasectomy

For Females:

__Augmentation Mammoplasty
__Bilat tubal ligation
__Breast biopsy
__Ceasarean section
__Pregnancy termination
__Hysterectomy
__Mastectomy
__Myomectomy
__Breast Reduction
__Total hysterectomy/Ovary removal
__Vaginal hysterectomy
Other:

Physicians you have seen in the past three years and why:________________________________

____

When was your last physical and with whom?______________________________________

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RELATIONSHIP	AGE	ILLNESSES IF ANY	IF DECEASED, AT WHAT AGE	CAUSE OF DEATH
Mother				
Father				
Sister				
Sister				
Brother				
Brother				
Maternal Aunt				
Maternal Uncle				
Paternal Aunt				
Paternal Uncle				
Maternal Grandparents				
Paternal Grandparents				

SOCIAL HISTORY

Birthplace ______________________

Education -- last year completed ____________________________

Do you use tobacco? Y N former (year quit ________) Type _____________________

Ever tried to quit? Y N # of years of tobacco use _________

Packs per day _______ Second hand smoke exposure? Y N

Do you drink alcoholic beverages? Y N # per week? ____

If no, did you previously drink regularly? Y N

Do you drink caffeine beverages? Y N Coffee ____ Tea ____ Sodas ____ # per week? _____

Do you exercise? Y N Type ____________ Frequency ______________ Duration ___________

Hobbies and activities ____

Do you use a seatbelt when driving? Y N

Do you have an Advance Medical Directive in place? Y N Is it on file with us? Y N

Who do you live with at home?____

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

_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________

List any medication allergies or adverse reactions:

____
____

Immunizations Have you had these vaccinations? If so when (date(s)) and where (location)?

Hepatitis A ______________________ Polio Injection or oral ______________________
Hepatitis B ______________________ Tetanus/DTAP ______________________
HPV (Gardasil) ______________________ Typhoid ______________________
Influenza ______________________ Varicella ______________________
Measles, Mumps, Rubella ______________________ Yellow Fever ______________________
Meningitis ______________________ Zoster (Shingles) ______________________
Pneumonia ______________________

Health maintenance:

Last pap **date**______________
Last mammogram **date**______________
Last colonoscopy **date**______________
Last bone density **date**______________

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Please check problems you have, if any:

Constitutional	**Eyes**	**Gastrointestinal**	**Endo/Heme/Aller**
__Fever	__Blurred vision	__Heartburn	__Easy bruise/bleed
__Chills	__Double vision	__Nausea	__Environmental Allergies
__Weight loss	__Discomfort with bright light	__Vomiting	__Excessive amounts of urine
__Malaise/Fatigue	__Eye pain	__Abdominal pain	**Neurological**
__Sweats	__Eye discharge	__Diarrhea	__Dizziness
__Weakness	__Eye redness	__Constipation	__Tingling
Skin	**Cardiovascular**	__Blood in stool	__Tremor
__Rash	__Chest pain	__Black stool	__Sensory change
__Itching	__Palpitations	**Genitourinary**	__Speech change
HENT	__Shortness of breath when lying flat	__Painful urination	__Focal weakness
__Headaches	__Leg pain	__Urgency	__Seizures
__Hearing loss	__Leg swelling	__Frequency	__Loss of consciousness
__Ringing in the ears	__Wakes up due to shortness of breath	__Blood in urine	**Psychiatric**
__Ear pain	**Respiratory**	__Flank pain	__Depression
__Ear discharge	__Cough	**Musculoskeletal**	__Suicidal ideas
__Nosebleeds	__Coughing up blood	__Muscle aches	__Substance abuse
__Congestion	__Productive cough	__Neck pain	__Hallucinations
__Throat tightness	__Shortness of breath	__Back pain	__Nervous/Anxious
__Sore throat	__Wheezing	__Joint pain	__Insomnia
		__Falls	__Memory loss