Place Label Here

Name:_____

DOB: _____

Stanford HEALTH CARE

Health Questionnaire

Please arrive 30 minutes prior to your appointment

Last Name:	First Name:	DOB:	○ F ○ M ☐ Other
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ 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?

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

Surgical and Hospitalization History (include dates)

Family History *(Use back of page if needed)*			**Age**	**Medical conditions** Indicate **Healthy** -or- diabetes, high blood pressure, cholesterol, heart disease, stroke, cancer (type)
Mother		□ Living □ Deceased		
Father		□ Living □ Deceased		
Sibling	□ F □ M	□ Living □ Deceased		
Sibling	□ F □ M	□ Living □ Deceased		
Sibling	□ F □ M	□ Living □ Deceased		
Sibling	□ F □ M	□ Living □ Deceased		
Grandmother Mother's Side		□ Living □ Deceased		
Grandfather Mother's Side		□ Living □ Deceased		
Grandmother Father's Side		□ Living □ Deceased		
Grandfather Father's Side		□ Living □ Deceased		
Children	□ F □ M	□ Living □ Deceased		
Children	□ F □ M	□ Living □ Deceased		
Extended Family Members			□ Cancer	□ Heart attacks □ Stroke □ Diabetes

Patient History		
Smoking	**Cigarette Use:**	□ Never □ Former Smoker Date quit or age: □ Current Smoker
	Other tobacco use:	□ Pipe □ Cigars □ Chewing Tobacco
	Other:	□ e-Cigarettes □Marijuana
Alcohol	**Do you drink alcohol?**	□ Yes □ 0-1 times/month □ 2-4 times/month □ Every week □ 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?	□ Yes □ No
	Do people annoy you by nagging about your drinking?	□ Yes □ No
	Have you ever felt guilty about drinking?	□ Yes □ No
	Have you ever had a morning drink to steady your nerves?	□ Yes □ No
Drugs	Have you used recreational or street drugs within the last two years?	□ Yes □ No
	Have you ever used recreational drugs with a needle?	□ Yes □ No
Sexual Health	□ Sexually active □ Not currently sexually active □ Never sexually active	
	Sexual Partners: □ Men □ Women # of Partners in last year: _____	
	History of Sexually Transmitted infections? If yes, type/dates: _____	
	Current contraception method: _____ Previous methods: _____	
	Women: # of children:_____ # of pregnancies:_____ # of miscarriages:_____ # of abortions:_____ Date of last menstrual period: _____	

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

Immunizations	**Date**	**Immunization**	**Date**
☐ Flu Vaccine		☐ TD (Tetanus Shot)	
☐ TDAP (Whooping Cough/Tetanus)		☐ Zostavax (Shingles) ☐ Shingrix (Shingles)	
☐ Pneumococcal PCV13		☐ HPV	
☐ Pneumococcal PPV23		☐ Meningococcal ACWY	
☐ Hepatitis A		☐ Meningococcal B	
☐ Hepatitis B		☐ 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)