

Stanford Primary Care Clinics Patient Questionnaire - Adult

FIRST NAME: _____ LAST NAME: _____ DOB: _____

CHECK ALL THAT APPLIES TO PAST AND PRESENT MEDICAL CONDITIONS

- | | | |
|--|--|---|
| <input type="checkbox"/> Alcohol/Drug Problem | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Sexual Transmitted Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcers of the Stomach |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Coronary Artery/Heart Disease | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Peripheral Artery Disease | |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Positive TB Test | |

IMMUNIZATIONS

Flu Vaccine	Date:
Pneumococcal Vaccine	Date:
Tetanus, Diphtheria - with or without Whooping Cough (circle one)	Date:
Shingles	Date:
Screening Tests – Gardasil	Date:

MEDICATIONS – including OVER THE COUNTER medications

NAME	DOSE & DIRECTIONS	REASON
Mammogram	Date last performed:	
Pap Smear	Date last performed:	
Colonoscopy or other cancer screening	Date last performed:	

"This form is not to be included or scanned into the patient's Medical Record"

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ALLERGIES TO MEDICATIONS or FOOD	REACTION/COMMENTS

OTHER MEDICAL HISTORY

SURGICAL HISTORY (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cesarean Section | <input type="checkbox"/> Hysterectomy –Partial |
| <input type="checkbox"/> Cardiac Angioplasty, Stent or Bypass | <input type="checkbox"/> Gall Bladder - Laparoscopic | <input type="checkbox"/> Hernia Repair |
| <input type="checkbox"/> Cardiac Catheterization | <input type="checkbox"/> Gall Bladder - Open | <input type="checkbox"/> Prostrate Surgery |

OTHER SURGICAL HISTORY

TOBACCO USE (circle the appropriate answer)

SMOKING: Never Previous Current Packs per Day: Years:
 Quit Date:

ALCOHOL: Never Occasional Excessive

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

of Can(s) of beer (12oz) # of glasses of glasses (6oz) # of Drink(s) containing 0.5oz of Alcohol

DRUG USE (circle the appropriate answer) if yes, this will be discussed with the physician

No Yes

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FAMILY HEALTH HISTORY

Family Member	Living (L)	Medical Conditions Please specify Premature Heart Disease, Diabetes Mellitus , Cancer of any type, Prostate, Breast, Ovarian problems
	Deceased (D)* Unknown (U)	
Mother		
Father		
Mother's Mom		
Mother's Dad		
Father's Mom		
Father's Dad		
Sister		
Brother		
***** If deceased, please indicate age		

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