STANFORD
HOSPITAL & CLINICS
Stanford University Medical Center

Stanford Primary Care Clinics
Patient Questionnaire - Adult

FIRST NAME: _____ LAST NAME: _____ DOB: _____

CHECK ALL THAT APPLIES TO PAST AND PRESENT MEDICAL CONDITIONS

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

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)

☐ Appendectomy
☐ Cardiac Angioplasty, Stent or Bypass
☐ Cardiac Catheterization
☐ Cesarean Section
☐ Gall Bladder - Laparoscopic
☐ Gall Bladder - Open
☐ Hysterectomy –Partial
☐ Hernia Repair
☐ 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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FIRST NAME: _____ LAST NAME: _____ DOB: _____

FAMILY HEALTH HISTORY

Family Member	Living (L) Deceased (D)* Unknown (U)	Medical Conditions Please specify Premature Heart Disease, Diabetes Mellitus , Cancer of any type, Prostate, Breast, Ovarian problems
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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