



Medical Record Number

Patient Name

CLINICS • ORTHOPAEDIC SURGERY • NEW PATIENT

QUESTIONNAIRE Page 1 of 5

Addressograph or Label - Patient Name, Medical Record Number

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

Patient Name: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Age: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Pharmacy (Name, Address, Telephone): \_\_\_\_\_

Current Occupation: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

When did you first become aware of this problem: \_\_\_\_\_

**PAST MEDICAL HISTORY:** Check YES or NO for any significant conditions that apply.

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

Do you have a pacemaker or internal defibrillator?  YES  NO Describe: \_\_\_\_\_

Have you noticed any lumps or bumps? State location: \_\_\_\_\_

Other (describe) \_\_\_\_\_

**Surgeries** - 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): \_\_\_\_\_

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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:  YES  NO If yes, how often and how much? \_\_\_\_\_

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

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: \_\_\_\_\_

Travel outside of the United States: \_\_\_\_\_

Marital status/Relationship: \_\_\_\_\_

Who currently lives at home with you? \_\_\_\_\_



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**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:
<b>Constitutional</b>				
good health	<input type="checkbox"/>	<input type="checkbox"/>		
recent weight changes	<input type="checkbox"/>	<input type="checkbox"/>		
recurrent fevers, chills, sweats	<input type="checkbox"/>	<input type="checkbox"/>		
fatigue	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Eyes</b>				
wear glasses/contact lenses	<input type="checkbox"/>	<input type="checkbox"/>		
blurred or double vision	<input type="checkbox"/>	<input type="checkbox"/>		
change in vision	<input type="checkbox"/>	<input type="checkbox"/>		
glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Ears/Nose/Mouth/Throat</b>				
change in hearing	<input type="checkbox"/>	<input type="checkbox"/>		
ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>		
recent nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>		
chronic sinus problems	<input type="checkbox"/>	<input type="checkbox"/>		
mouth sores	<input type="checkbox"/>	<input type="checkbox"/>		
frequent sore throats	<input type="checkbox"/>	<input type="checkbox"/>		
voice changes	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Respiratory</b>				
asthma or wheezing	<input type="checkbox"/>	<input type="checkbox"/>		
breathing problems	<input type="checkbox"/>	<input type="checkbox"/>		
coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>		
chronic cough	<input type="checkbox"/>	<input type="checkbox"/>		
pneumonia	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Cardiovascular</b>				
heart trouble or heart attack	<input type="checkbox"/>	<input type="checkbox"/>		
chest pain or angina	<input type="checkbox"/>	<input type="checkbox"/>		
shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>		
palpitations	<input type="checkbox"/>	<input type="checkbox"/>		
swelling of feet, ankles or hands	<input type="checkbox"/>	<input type="checkbox"/>		
blood clots	<input type="checkbox"/>	<input type="checkbox"/>		
varicose veins	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Gastrointestinal</b>				
change in appetite	<input type="checkbox"/>	<input type="checkbox"/>		
severe heartburn	<input type="checkbox"/>	<input type="checkbox"/>		
bleeding ulcers	<input type="checkbox"/>	<input type="checkbox"/>		
frequent nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>		
vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>		
frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>		
constipation/painful bowel movements	<input type="checkbox"/>	<input type="checkbox"/>		
black or bloody stools	<input type="checkbox"/>	<input type="checkbox"/>		
rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>		
abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Genitourinary</b>				
blood in urine	<input type="checkbox"/>	<input type="checkbox"/>		
burning with urination	<input type="checkbox"/>	<input type="checkbox"/>		
change in force of stream when urinating	<input type="checkbox"/>	<input type="checkbox"/>		

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





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Signature of Person Completing this Form

Relationship (if other than Patient)

Print Name

Date

Time

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/Title

Print Name

Date

Time

The preceding information was also reviewed by:

Provider Signature/Title

Print Name

Date

Time

Provider Signature/Title

Print Name

Date

Time

Provider Signature/Title

Print Name

Date

Time

## New Patient Full Registration Form

Today's Date \_\_\_\_\_

### Patient Information

Patient Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Street Address \_\_\_\_\_ Sex circle: M F

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ DOB \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_ Work \_\_\_\_\_

Patient Employer \_\_\_\_\_ Employment Status \_\_\_\_\_

Language \_\_\_\_\_ Need Interpreter? \_\_\_\_\_

Marital Status \_\_\_\_\_ Maiden Name \_\_\_\_\_

Ethnicity \_\_\_\_\_ Stanford Affiliation \_\_\_\_\_

Religion \_\_\_\_\_

### Person Responsible for Payment ("Guarantor")

Responsible Party Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
(Person responsible for payment) (For example: self, spouse, parent, other)

Street Address \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Sex circle: M F

Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Responsible Party Employer \_\_\_\_\_

### Patient Contacts

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Additional Contact Name and # (if needed) \_\_\_\_\_ Relationship \_\_\_\_\_

### Primary Care Physician Information

Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Other Physician \_\_\_\_\_ Phone \_\_\_\_\_

*Copy of Patient's Insurance Card attached*