Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305

CLINICS • ORTHOPAEDIC SURGERY • NEW PATIENT QUESTIONNAIRE

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

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

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

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

STANFORD

Stanford Orthopaedic Surgery
Matt Miller, M.D.
Zackary Vaughn, M.D.

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