Medical Record Number

Patient Name

## STANFORD HOSPITAL and CLINICS STANFORD, CALIFORNIA 94305



CLINICS • ORTHOPAEDIC SURGERY • NEW PATIENT

QUESTIONNAIRE

Page 1 of

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

Medical Record Number Patient Name

CLINICS • ORTHOPAEDIC SURGERY • NEW PATIENT

Addressograph or	Label - Patient Name, Medical Record Number	QUE	STIONNAIRE Page 2 of 5
Have you had sig	nificant exposure to: Pestic	cides? YES NO	Toxic waste? YES NO
Have you had pre	evious treatment with or expo	osure to radiation? 🔲 YE	S 🔲 NO
If YES, explain: _	Veight: Height:	V	Patient Name
FAMILY HISTORY	Υ		
List health pro	blems in your family:		
Ag	ge Medical Proble	ms If Decea	sed, Cause of Death
Father _			re amonad had one lists north
Mother	that we different transitionie	Check VFS or NO for mo	PAST MEDICAL HISTORY
Siblings _	Have Fever Strict to Perchants	INTER TINE	simenA
ONES ON	Heart Propiems	reema LYES LINC	Asthma/Bronchitts/Emphy
Spouse	audageri (	DAES CLAC	Armos
Children	High Blood Pressure	Disorder TAES TING	Bleeding/Bruising/Blood L
OILD SEAD	Immune Disorder	DN [] S3A[]	Cancer (type)
ONE SEVE	Namey Disorder	DM C 831 C	Depression
Grand-	Stroke	cent Caves Line	Insulin Injection Depen
parents _	D Thyroid Disease	L CAKES DINC	Non-Insulin Dependen
SOCIAL HISTOR	V (BT) sisolucidad (TS)		
Tobacco use:			
Cigarettes:	Pack(s) per day:	How many years:	If you quit, when?
	use: Amount per day:	How many years:	THE MOUST MOVED AND TANKED IN
	ES NO If yes, how often		(6010000) 1015
	Irugs other than prescribed		ation? YES NO
If yes, please		onanzations, major surger	sou deucher : cret brewone nost
Do you eat a bala	anced diet? YES NO	Is your weight stable	e? YES NO
	r important information the o	doctor should know:	
ne-counter drugs):	ges (prescription and all over-th	ns you are taking and does	Medications - List all medication
Birthplace:			

Marital status/Relationship:

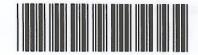
Travel outside of the United States:

Who currently lives at home with you?\_

Medical Record Number

Patient Name

STANFORD HOSPITAL and CLINICS STANFORD, CALIFORNIA 94305



CLINICS • ORTHOPAEDIC SURGERY • NEW PATIENT

QUESTIONNAIRE Page 3 of

Addressograph or Label - Patient Name, Medical Record Number

## **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				Ment at the same
good health	LU		100	aronou arasord
recent weight changes	U			Sciolar wasses
recurrent fevers, chills, sweats			0.0	Women;
fatigue			- - - -	pain/problems with periods
Eyes				abnormal uterine bleeding
wear glasses/contact lenses				uterine tumors
blurred or double vision				Neurological
change in vision				headaches
glaucoma				numbness or tingling sensations
Ears/Nose/Mouth/Throat	_	_		weatoness or paralysis
change in hearing				conversions or solutions
ringing in the ears				militarina process de visionasim ni appredo
recent nose bleeds				February Dures and CA spectaneous was tel
chronic sinus problems				foremotion rates turned from toximological
mouth sores			1717	GRIGHT HIRIU
frequent sore throats		-		Leconeni rasnes
				changing mores
voice changes			1-3-1-3-1	Sim cancer or metanomia
Respiratory				non-healing wounds
asthma or wheezing		4		change in Isair or nails
breathing problems			Last I have	breast pain or lump
coughing up blood		Ц		Psychiatric
chronic cough				memory loss or confusion
pneumonia				nervnusness
Cardiovascular				aniz smrah
heart trouble or heart attack				apple of paneds
chest pain or angina				Intelestant contin
shortness of breath				miner to establish total
palpitations				TORN SIMILESS OF DAME
swelling of feet, ankles or hands				muscus ban or diamphili
blood clots			1-	Mealuress of unscrees of lorus
varicose veins				Dunienth watered
Gastrointestinal				back pain
change in appetite				Endocrine
severe heartburn				heat or cold intolerance
bleeding ulcers		- 13		excess thirst or unation
frequent nausea/vomiting		- 1		thyroid problems
vomiting blood		-		Allergic/Immunologic
frequent diarrhea		-		low resistance to infection
frequent diarrhea				recent cold or flu
constipation/painful bowel				environmental alleroies
movements		4		reaction to medication(s)
black or bloody stools				
rectal bleeding				telanus popaler within past 10 years
abdominal pain				other immunizations up to date
Genitourinary				Hematologic/Lymphatic
blood in urine				easy bruising
burning with urination				frequent bleeding
change in force of stream when urinating				enlarged lymph nodes

Medical Record Number

Patient Name

CLINICS • ORTHOPAEDIC SURGERY • NEW PATIENT

Addressograph or Label - Patient Name, Medica			words to	QUE	S I I UNINAIRE Page 4 or 5
	Yes	No	Patient Explanation:		Provider Comments:
Genitourinary (continued) sexually transmitted disease		-	ptoms in for following area		Do you presently have any problen
sexually transmitted disease					If "YES", give an explanation.
change in sexual function or interest			No I Destant Eventuer		
Men:		ATTOM	analiques shallant		Constitutional
prostate trouble					Wikeri hoon
scrotal masses			H		pannerio Irinew Ingost
Women:					recurrent levers chills sweats
pain/problems with periods					minite)
abnormal uterine bleeding					env9
uterine tumors	n	T			were clare ens/contact lenses
		_			blurred at double diston
Neurological					rolan al aparta
headaches		-	-		Transcript in agreement
numbness or tingling sensations		-			townstTieth walkformed are 3
weakness or paralysis		-	1		INDITE THOOM (SEOM SELECT
convulsions or seizures		-			- United to Spinite
change in memory or concentration					shoold coop treem
Integumentary (Skin and Breasts)					sheem need needs
birth marks	4	4			Chalcold some allowing
recurrent rashes	4	1			Egypta Handell
changing moles	Ц				medinen sore anoms
skin cancer or melanoma	Ц				safuruo anov
non-healing wounds					respiratory
change in hair or nails	LU				grisserw to smittee
breast pain or lump					Sulaidoid fumpaio
Psychiatric					confining his proof
memory loss or confusion					chromic cough
nervousness					Puomuang
depression					Cardiovascular
change in sleep					heart frouble or heart affack
Musculoskeletal					chest pain or angina
joint stiffness or pain					shortness of breath
					palphations
muscle pain or cramping	F				swelling of feet, ankles or hands
weakness of muscles or joints					blood clots
difficulty walking	H	<del>       </del>			varicose veins
back pain					Gestrointestinal
Endocrine					change in appetite
heat or cold intolerance					Severa presupply
excess thirst or urination		13			bleeding ulcers
thyroid problems		1 4			requent nausea/vomiting
Allergic/Immunologic					boold podimay
low resistance to infection	4	14			frequent diarrises
recent cold or flu		14			constipation/paintul bownl
environmental allergies	Ц	1			movements
reaction to medication(s)					black or bloody stools
tetanus booster within past 10 years					nectal bleedung
other immunizations up to date					abdominal pain
Hematologic/Lymphatic			_		Senttourinary
easy bruising					blood in urine
frequent bleeding					nodennu with unnation
enlarged lymph nodes					change in force of stream when
omargou ijinpii nodoo	15000				Onifornia

Medical Record Number

Patient Name



STANFORD HOSPITAL and CLINICS STANFORD, CALIFORNIA 94305

Addressograph or Label - Patient Name, Medical Record Number

**CLINICS • ORTHOPAEDIC SURGERY • NEW PATIENT** QUESTIONNAIRE Page 5 of 5

Signature of Person Completing this Form	Relationship (if other than Patient)			
Print Name	Date	1	lime lime	
PROVIDER	R DOCUMENTAT	TION		
Instructions to Attending Physician: Your signature below indicates that you had questionnaire and that you have reviewed the Key finding(s) must be summarized in you referenced for additional details.	pertinent or key	finding(s) with	the patient and/or family	
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	
		Date	Time	



## New Patient Full Registration Form

Today's Date			
Patient Information			
Patient Name		Social Security Number	
Street Address			
		Zip DOB	
		Work	
Patient Employer		Employment Status	
Language		Need Interpreter?	
Marital Status		Maiden Name	
Ethnicity		Stanford Affiliation	
Religion	200		
Person Responsible for Payment ("G	uarantor")		
Responsible Party Name(Person responsible for payment)		Relationship to Patient (For example: self, spouse, parent, other)	
Street Address	-	DOB	
City	State	Zip Sex circle: M F	
		Work Phone	
Responsible Party Employer			
Patient Contacts			
Emergency Contact Name		Relationship	
		Work Phone	
	eded)	Relationship	
Primary Care Physician Information			
Referring Physician		Phone	
Primary Care Physician	****	Phone	
Other Physician	Walter Committee	Phone	17

Copy of Patient's Insurance Card attached