



SMG Patient History Form

Stanford Medical Group ● Stanford Hospital and Clinics ● smg.stanford.edu

NAME: _____

Date of Birth: _____

DATE: _____

Past Medical History (Please list dates and hospital if known):

Current Medical Problems	Previous Surgical Problems	Previous Hospitalizations
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.
6.	6.	6.

Current Medications (names, dose, and frequency; include vitamins and over the counter drugs):

1.	4.	7.
2.	5.	8.
3.	6.	9.

Allergies to Medications (name and reaction if known):

1.	2.	3.
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Immunizations: (name and date if known):

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Family Health History (Please list known Medical Problems)

Family Member	Current Age	Medical Problems
Grandparents		
Father		
Mother		
Brothers/Sisters		

Preventive Health Issues

Exercise

Types of activity: _____

Frequency (times/week): _____ Intensity (duration/target pulse): _____ Years exercising: _____

Diet

Do you limit caloric intake? Yes ___ No ___ Do you limit fat and cholesterol intake? Yes ___ No ___

Other Prevention Behaviors and Screening

Seatbelt Use? Yes ___ No ___ Smoke Detector? Yes ___ No ___ Bicycle Helmet? Yes ___ No ___

Do you have a strategy to protect yourself against infection by the AIDS Virus (HIV)? Yes ___ No ___

Smoking History? Yes ___ No ___ Amount _____ Alcohol use? Yes ___ No ___ Amount _____

Last Cholesterol check (date and level if known): _____

Last Mammogram (date and result if known): _____

Last PAP test (date and result if known): _____

Last Colon cancer screening (date and result if known): _____

When was your last complete exam with your previous doctor? _____

Current Health Concerns and Goals

Please List Current Health Concerns and your Health Goals:
