SHARP Rees-Stealy Medical Centers

Do not use this form for life- or limb-threatening emergencies. The information you provide in this form will not be reviewed until just prior to your visit. For urgent matters, please call your doctor's office.

Patient Questionnaire

Name: _____ Date of birth: _____

Name of the doctor you will be seeing: _____

Your best daytime phone #: _____ Your preferred method of contact: ☐ Phone call ☐ FollowMyHealth

Sex: Select one If other, please specify: _____ Preferred language: _____

Occupation: _____ Education level completed: _____

Country and City of birth: _____ Preferred pharmacy: _____

Medical Illnesses Current or past (Check all that apply)

☐ I'm an existing patient and have no updates to this section since my last visit.

☐ Cancer (Type: _____)

☐ Alcoholism/Drug addiction
☐ Blood clots
☐ Depression/Anxiety
☐ Diabetes
☐ Glaucoma
☐ Heart disease
☐ Hepatitis
☐ High blood pressure
☐ HIV
☐ Kidney disease
☐ Lung disease
☐ Migraines
☐ Seizures
☐ Strokes
☐ Thyroid condition

Is there anything else about your medical history that you feel your doctor should know? Please Explain.

Surgeries Please list any surgeries you've had and the date of each.

☐ I'm an existing patient and have no updates to this section since my last visit.

Type of surgery	Date of Surgery

Other Visits Please list any hospitalizations, emergency room or urgent care visits or nursing home admissions.

☐ I'm an existing patient and have no updates to this section since my last visit.

Type of visit	Date of visit
Select one	
Select one	
Select one	
Select one	

Medications Please list all medications you are currently taking, including vitamins, supplements or herbs.

☐ I'm an existing patient and have no updates to this section since my last visit.

Name of medication	Dosage	How many times per day?

Allergies Please list any allergies.

☐ I'm an existing patient and have no updates to this section since my last visit.

Name of medication or allergen	Type of reaction

Vaccines

For New Patients Only

Please enter the most recent date administered for the following:

Tetanus/Tdap	Flu shot	Shingles vaccine	Pneumonia vaccine

Family History Please indicate any illnesses that are present in your family.

☐ I'm an existing patient and have no updates to this section since my last visit.

☐ I do not know my family history.

Illness	Father	Mother	Sibling	Child	Other (please specify)
Alcohol abuse	☐	☐	☐	☐	
Drug abuse	☐	☐	☐	☐	
Breast cancer	☐	☐	☐	☐	
Colon cancer	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	
Mental illness	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	
Heart disease	☐	☐	☐	☐	
High blood pressure	☐	☐	☐	☐	
Ovarian cancer	☐	☐	☐	☐	
Endometrial cancer	☐	☐	☐	☐	
Prostate cancer	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	
Sudden death in family member (seemed healthy)	☐	☐	☐	☐	
Thyroid condition	☐	☐	☐	☐	
Other (please specify)	☐	☐	☐	☐	
Other (please specify)	☐	☐	☐	☐	

Social History

☐ I'm an existing patient and have no updates to this section since my last visit.

Marital status Select one

Sexual orientation Select one

If other, please specify _____

Do you have children? Yes ◯ No ◯ If yes, how many? _____

Do you use birth control? Yes ◯ No ◯ If yes, please indicate type: _____

Do you live alone? Yes ◯ No ◯

Do you have a history of domestic violence? Yes ◯ No ◯

Do you smoke? Select one

If you are a former smoker, please provide the following:

Date you quit smoking: _____

Number of years you smoked: _____

Average number of packs per day: _____

If you are a current smoker, please provide the following:

Number of years you have been smoking: _____

Average number of packs per day: _____

Do you have a history of alcohol abuse? Yes ◯ No ◯

If yes, please indicate the date you quit drinking: _____

Please refer to the following scale to determine your current level of alcohol use.

For women:
Minimum = occasional or social
Moderate = one drink per day
Heavy = two or more drinks per day
Binge = four or more drinks within two hours

For men:
Minimum = occasional or social
Moderate = two drinks per day
Heavy = three or more drinks per day
Binge = five or more drinks within two hours

Alcohol use: Select one

Do you have a history of drug use? Yes ◯ No ◯
If yes, please indicate which drugs you have used in the past:
☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Amphetamines ☐ Other
Do you currently use drugs? Yes ◯ No ◯
If yes, please indicate which drugs you currently use:
☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Amphetamines ☐ Other
Do you use caffeine? Yes ◯ No ◯ If yes, please indicate type and ounces per day: _____
Do you exercise? Yes ◯ No ◯ If yes, how often? _____

If you are 50 years or older, please provide the most recent dates for any colon cancer screenings you have had.

Stool cards	Sigmoidoscopy	Colonoscopy
_____	_____	_____

☐ I've never had a colon cancer screening.

If you are female, please complete the following:

Have you ever been pregnant? Yes ◯ No ◯
If yes, how many pregnancies? _____ And, how many live births? _____
When was your last period? _____
When was your last Pap smear? (21 years and older) _____
When was your last mammogram? (40 years and older) _____

If you are 65 years or older, please answer the following:

Please indicate how many days in a given week the following statements are true:

I have little interest or pleasure in doing things
Select one

I feel down, depressed or hopeless
Select one

Have you fallen in the last calendar year? Yes ◯ No ◯ If yes, how many times? _____
Were you injured? Yes ◯ No ◯

Do you have an advance health care directive? (If yes, please bring it with you to your upcoming appointment.)

Yes ◯ No ◯

Thank you for taking the time to fill out this questionnaire in preparation for your upcoming visit.

Form Instructions
Please return your completed form to Sharp Rees-Stealy in one of the following ways:

- Fax it to 858-636-2424, Attn: ROI Specialist
- Mail it to Sharp Rees-Stealy Central Records Room, Attn: Medical Records, 4000 Ruffin Road, Suite R, San Diego, CA 92123
- Email* it to srs.forms@sharp.com
- Bring it with you at the time of your appointment

*Your privacy is important to us. Please use the email option if you have a personal email account that only you can access.