EMORY HEALTHCARE

Clinic Number:_____ Name:_____

Home Phone: _____ DOB:_____ Age:_____

Work Phone:_____ Today's Date:_____

Please fill out the following information so that we may have an understanding of your current medical status.

Current Medications (name of the drug and the dosage):

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

Do you take any:

☐ Herbal Products
☐ Vitamins
☐ Minerals

Do you need refills on any of these medicines today? ☐ Yes ☐ No

Drug Allergies: Please check or list all drugs and the type of reaction

☐ I am not allergic to any medications

☐ Penicillin Reaction_____

☐ Sulfa Reaction_____

☐ Codeine Reaction_____

_____ Reaction_____

_____ Reaction_____

Medical Problems: Have you had (or do you have now) any of the following medical problems:

☐ High Blood Pressure
☐ Heart Disease
☐ Heart Attack
☐ Stroke
☐ Diabetes
☐ Thyroid Disease
☐ Positive HIV or AIDS
☐ Breast Cancer
☐ Other Cancer
☐ Colon Cancer
☐ Abnormal PAP
☐ Hepatitis or Jaundice
☐ Liver/Pancreas Disease
☐ Other (describe)_____
☐ Asthma
☐ Emphysema
☐ Tuberculosis
☐ Sickle Cell
☐ Anemia
☐ Arthritis
☐ Kidney Stones
☐ Urinary Tract Infection
☐ Other Kidney Disease
☐ Seizure Disord
☐ Received Blood Transfusion
☐ Sexually Transmitted Disease

_____

Past Surgery

☐ Appendix _____ year
☐ Hernia _____ year
☐ Tonsils _____ year
☐ Gall Bladder_____ year
☐ Heart_____ year
☐ Other (describe)_____
☐ Thyroid _____ year
☐ Lung _____ year
☐ Hysterectomy_____ year
☐ Spine/joint_____ year

_____

_____

Year	Reason		Year	Reason

Smoking and Alcohol History:

Cigarettes: Do you smoke now: ☐ Yes ☐ No Have you smoked in the past: ☐ Yes ☐ No

How many years did you smoke:_____ When did you quit: _____

Do you use other tobacco products: ☐ No ☐ Cigars ☐ Chewing Tobacco ☐ Snuff ☐ Other

How much alcohol do you drink: ☐ None ☐ 1-7 drinks/week ☐ 8-14 drinks/week ☐ more than 14/week

Please continue to next page:

Social History:

Coffee/Tea: cups or glasses per day:_____ Occupation:_____

Marital Status: ☐ Single ☐ Married (Spouse's name/age:_____) ☐ Divorced ☐ Separated ☐ Widowed

Children's names and ages:_____

Do you exercise regularly? ☐ Yes ☐ No Have you signed your Drivers License as an organ donor? ☐ Yes ☐ No

In the last year have you traveled outside the country? ☐ Yes ☐ No If yes, where:_____

Do you have pets at home: ☐ Cats ☐ Dogs ☐ Birds ☐ Fish ☐ Other_____

Personal Safety

Do you wear seat belts? ☐ Always ☐ Often ☐ Occasionally ☐ Never

Do you have firearms in your home ☐ Yes ☐ No If yes, are they kept locked up? ☐ Yes ☐ No

Please note: HIV, the virus that causes AIDS, is spread by blood or sexual contact. If you have had multiple sexual partners or have used IV drugs presently or in the past, you should consider discussing HIV testing with your health care provider.

Family History (for blood relatives only) check if any relative had any of the following diseases:

For parents and grandparents, please enter the current age if living or age at the time of death if deceased and then check if they had any of these diseases.

	Living?	Age	High Blood Pressure	Heart Disease	Diabetes	Colon Cancer	Breast/ Prostate Cancer	Other Cancer	Other Problems (describe)
Father	☐Y ☐N		☐	☐	☐	☐	☐	☐	
Grandfather	☐Y ☐N		☐	☐	☐	☐	☐	☐	
Grandmother	☐Y ☐N		☐	☐	☐	☐	☐	☐	
Mother	☐Y ☐N		☐	☐	☐	☐	☐	☐	
Grandfather	☐Y ☐N		☐	☐	☐	☐	☐	☐	
Grandmother	☐Y ☐N		☐	☐	☐	☐	☐	☐	
Any brother/sister			☐	☐	☐	☐	☐	☐	

Other diseases in your family:

☐ Stroke ☐ Tuberculosis ☐ Goiter ☐ Anemia
☐ Kidney Disease ☐ Sickle Cell ☐ Bleeding problems ☐ Other Cancer_____
☐ Asthma ☐ Leukemia or Lymphoma ☐ Depression or other psychiatric illness

Immunizations: Please enter information about immunizations you have had:

Tetanus: _____year Pneumonia: ☐Yes ☐No Chicken Pox: ☐Yes ☐No
Influenza (Flu): _____(yr) Hepatitis A: ☐Yes ☐No Hepatitis B: ☐Yes ☐No
Tuberculosis Skin Test: _____(yr) Tb test positive? ☐Yes ☐No

If you were born after 1957, have you received a second measles vaccination? ☐Yes ☐No

Are you presently seeing any other physicians: if yes, please list their name and specialty

Non-physician health care providers (chiropractors, homeopaths, etc.)

Advanced Directives: Do you have a living will or medical durable power of attorney:

☐I have a living will ☐I have signed a medical durable power of attorney ☐I'm interested in learning about these