



INITIAL HISTORY FORM

Welcome to the Infectious Diseases Clinic of Emory Healthcare. In order to get to know you better and help you with any problem you might have, please fill out this questionnaire to the best of your knowledge. If you are not sure, please mark the question with a question mark and we will discuss it with you later.

Name: _____ Date: ____|____|20____

Age: _____ Date of Birth ____|____|19____ Height: _____ inch Weight: _____ lbs

Reason for visit to the clinic: _____

Who is your primary provider? (Family doctor) Name: _____ Address: _____

Who referred you to our clinic? (If different from above) Name: _____ Address: _____

Would you want us to send results to any of your doctors? To whom? Name: _____ Address: _____

If we try to reach you, may we leave a message on your voice-mail/answering machine?

[] No [] Yes, preferred number: (____) ____ - ____ x _____

I would prefer fax/e-mail notification at: _____

Do you have a Living Will? [] No [] Yes [] Don't know

Does anybody have Power of Attorney? [] No [] Don't know [] Yes, _____

Would you like more information about living will/power of attorney? [] No [] Yes

Have you ever experienced an allergic reaction or intolerance to medications?

Table with 4 columns: Drug, Reaction, Drug, Reaction. Rows 1-3.

Do you have any other allergies (such as iodine, dye, nickel, food, hay fever)? _____

Have you ever received a blood transfusion? [] No [] Yes [] Don't know

If yes, why _____ when (MM/YY) ____|____

Are you taking any medications (including vitamins, herbs, over-the-counter pills)?

Name of drug	Dose (if known)	Taken how often a day/week?

Recreational Use

- Do you use Marijuana?** Never No longer use, quit _____ Yes
Do you use Cocaine? Never No longer use, quit _____ Yes
Do you use Heroin? Never No longer use, quit _____ Yes
Do you smoke? Never No longer use, quit _____ Yes, <1 pack/day 1 >1
Do you drink alcohol? Never No longer use, quit _____ Yes, <1 drink/day 1-3 >3
Did you ever have problems with alcohol? Yes No
Did you ever have a DUI? Yes No

Sexuality

- Are you sexually active?** Yes No
Do you have a steady partner? Yes No
Are you married? Yes No Divorced
 Separated Widowed
Do you consider yourself Heterosexual Homosexual Bisexual
Is your sexual interest High Medium Low
Do you use condoms? Never Sometimes Always
Number of sexual partners in preceding 3 months? _____

TB/Tuberculosis

- Have you ever been exposed to anyone with TB?** Yes No Unknown
 If yes, when? _____ How? _____
Have you ever had a tuberculosis (TB) skin test? Yes No Unknown
 If yes, when (MM/YY)? ____|____ What was the result? Pos Neg Unknown
 If the test was positive, did you receive medication? Yes No Unknown
 If yes, what medication _____ Start (MM/YY) ____|____ End ____|____

Are you experiencing significant problems or do you have concerns with any of the following?

No	Yes	General	Comment
<input type="checkbox"/>	<input type="checkbox"/>	Weight loss	_____
<input type="checkbox"/>	<input type="checkbox"/>	Weight gain	_____
<input type="checkbox"/>	<input type="checkbox"/>	Fever or chills	_____
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	_____
<input type="checkbox"/>	<input type="checkbox"/>	Problems with wound healing	_____
<input type="checkbox"/>	<input type="checkbox"/>	Increasing weakness	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	_____
<input type="checkbox"/>	<input type="checkbox"/>	Intolerance to heat or cold	_____
<input type="checkbox"/>	<input type="checkbox"/>	Lack of appetite	_____

No	Yes	Eyes, Ears, Nose, Throat	Comment
<input type="checkbox"/>	<input type="checkbox"/>	Blurred or bad vision	_____
<input type="checkbox"/>	<input type="checkbox"/>	Spots before your eyes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pain in the eyes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thrush	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mouth sores	_____
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty hearing	_____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent nose bleeds	_____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent sinus problems	_____

No	Yes	Respiratory	Comment
<input type="checkbox"/>	<input type="checkbox"/>	Cough	_____
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing/Asthma	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sputum production	_____
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	_____

No	Yes	Cardiovascular	Comment
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/discomfort/tightness	_____
<input type="checkbox"/>	<input type="checkbox"/>	Need to sleep with head up	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heartbeat irregular	_____
<input type="checkbox"/>	<input type="checkbox"/>	Recent fainting spell	_____
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet/legs	_____
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	_____
<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	_____
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic heart disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	_____

No	Yes	Gastrointestinal	Comment
<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	_____
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting blood	_____
<input type="checkbox"/>	<input type="checkbox"/>	Black & tarry stools	_____
<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	_____
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	_____
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion/Heartburn	_____
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea/Constipation	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	_____

No	Yes	Genitourinary	Comment
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	_____
<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	_____
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty holding urine	_____
<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	_____
<input type="checkbox"/>	<input type="checkbox"/>	Penile/vaginal discharge	_____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent vaginal yeast infection	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sores/lesions genitals	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pain/masses breasts	_____
<input type="checkbox"/>	<input type="checkbox"/>	Nipple discharge	_____

No	Yes	Musculoskeletal	Comment
<input type="checkbox"/>	<input type="checkbox"/>	Joint pain/swelling	_____
<input type="checkbox"/>	<input type="checkbox"/>	Body ache/muscle cramps	_____
<input type="checkbox"/>	<input type="checkbox"/>	Morning stiffness	_____

No	Yes	Endocrine	Comment
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst	_____
<input type="checkbox"/>	<input type="checkbox"/>	Change in breast size	_____
<input type="checkbox"/>	<input type="checkbox"/>	Change in body hair	_____

No	Yes	Neurologic/Psychiatric	Comment
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	_____
<input type="checkbox"/>	<input type="checkbox"/>	Headache	_____
<input type="checkbox"/>	<input type="checkbox"/>	Tingling/numbness	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleep disturbances	_____
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	_____
<input type="checkbox"/>	<input type="checkbox"/>	Depression	_____
<input type="checkbox"/>	<input type="checkbox"/>	Often feeling sad	_____
<input type="checkbox"/>	<input type="checkbox"/>	Spontaneous crying	_____
<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	_____

No	Yes	Skin/Hematologic	Comment
<input type="checkbox"/>	<input type="checkbox"/>	Itching	_____
<input type="checkbox"/>	<input type="checkbox"/>	Rash	_____
<input type="checkbox"/>	<input type="checkbox"/>	Skin problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding (gums/nose)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sickle trait	_____
<input type="checkbox"/>	<input type="checkbox"/>	Nail problems	_____

Gynecological History

Age when 1st period occurred: _____

Age at menopause: _____

No. of pregnancies: ___ No. of children: ___

No of miscarriages : ___ No of abortions: ___

Interval between periods (days): _____

Duration of periods (days): _____

Date of last period ____|____|_____

Are/were you periods regular? Yes No

Last PAP smear (MM/YY) ____|_____

Date of last mammogram ____|_____

Result: _____

Result: _____

Have any of your blood relatives had any of the following?

No	Yes		If so, who and what?
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell	_____
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other	_____

Support System

Who do you live with? _____

Where do you receive emotional support? _____

Who knows about your condition? _____

Who should not know? _____

Interests/Hobbies: _____

Education/Occupation

Last school attended

Grade School _____ years

High School _____ years

College _____ years

Post Grad _____ years

What is/was your occupation? _____

Are you currently employed? Yes, _____ hours/week Retired

No, year last worked _____ Disability

Is there anything else you believe we should know?
