

Medical History

Clinic Number: _____ Name: _____

EMORY HEALTHCARE

Home Phone: _____ DOB: _____ Age: _____

THE EMORY CLINIC, INC.

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:

- | | | |
|---|----------------------------------|----------------|
| <input type="checkbox"/> I am not allergic to any medications | <input type="checkbox"/> Codeine | Reaction _____ |
| <input type="checkbox"/> Penicillin | Reaction _____ | Reaction _____ |
| <input type="checkbox"/> Sulfa | Reaction _____ | Reaction _____ |

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

- | | | | |
|---|---|---------------------------------------|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Other Cancer | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other Kidney Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Abnormal PAP | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis or Jaundice | <input type="checkbox"/> Anemia | <input type="checkbox"/> Received Blood Transfusion |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Liver/Pancreas Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Positive HIV or AIDS | Other (Describe) _____ | | |

Past Surgery: Have you had any of the following operations, and the year:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Appendix _____ year | <input type="checkbox"/> Gall Bladder _____ year | <input type="checkbox"/> Thyroid _____ year | <input type="checkbox"/> Hysterectomy _____ year |
| <input type="checkbox"/> Hernia _____ year | <input type="checkbox"/> Heart _____ year | <input type="checkbox"/> Lung _____ year | <input type="checkbox"/> Spine/joint _____ year |
| <input type="checkbox"/> Tonsils _____ year | Other (Describe) _____ | | |

Hospitalizations: List any hospitalizations you have had other than surgery above or childbirth:

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 & 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 seatbelts: 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 contacts. 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 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	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grandfather	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grandmother	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mother	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grandfather	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grandmother	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Any Brother/Sister			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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 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.

Please continue to next page.

Review of Systems: Are you presently having any of the problems outlined below:

COMPLETE THIS SECTION ONLY IF YOU ARE HAVING A COMPLETE PHYSICAL EXAM TODAY

General:	Weight Loss.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Weight Gain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Loss of Appetite	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Fever.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Night Sweats.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skin	Skin problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Moles that have changed color or size	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Bruise easily.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eyes	Wear glasses or contact lenses	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Blurred vision.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Visual disturbances or Double Vision.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Cataracts or Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Eye pain.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ears	Ringing in your ears.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Ear pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Trouble hearing.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nose	Nosebleeds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Nasal congestion/drainage	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sinus infections.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies	Hay fever or Allergies (pollen seasons only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Hay fever or Allergies (year round)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Taken Allergy shots now or in the past	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mouth & Throat	Dental Problems/Dentures/Tooth Pain.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Mouth Sores.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sore Throat or Hoarseness (other than colds)....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Difficulty Swallowing.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Respiratory	Persistent cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Cough productive of sputum (phlegm).....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Coughing up blood	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Asthma or wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Exposure to Tuberculosis.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of Breath	At rest	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	With exercise, climbing hills or stairs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Wake up at night short of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sleep on more than one pillow in order to prevent shortness of breath at night.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart	Feel your heart racing even at rest	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Heart Palpitations.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Swelling of your feet or ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Pain in the leg or buttock when walking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Chest Pain or discomfort: At rest..... With exertion.....	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
Gastrointestinal	Indigestion or heartburn.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Frequent use of antacids or acid blockers.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Abdominal bloating.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Stomach Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Nausea or Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Vomiting blood	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Gallstones.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Hemorrhoids or rectal pain.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Diarrhea frequently or persistently	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Blood with bowel movement.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Black or tar-like stools	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Change in bowel habits recently.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Frequent use of laxatives.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Which laxative:

Genito Urinary	Get up more than once at night to urinate.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Discomfort, burning or stinging with urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Difficulty starting or stopping your urine stream.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Kidney stone	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Dark colored or cloudy urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Leaking bladder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Men ONLY	History of prostate trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Problems with erection/sexual difficulty.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Penile discharge	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Do you examine your testicles frequently.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Women ONLY	Age menses started _____			
	Date of last period _____			
	Number of Pregnancies _____			
	Births _____			
	Miscarriages _____			
	Abortions _____			
	Method of birth control _____			
	Do you examine your breasts regularly	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you ever taken birth control pills.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you noticed any breast lumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Vaginal discharge/discomfort at present time	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Irregular periods.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Bleeding when not your period.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Pain with intercourse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hot flashes	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Do you have a gynecologist:.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dr.'s Name: _____	
Muscles/Joints	Do you have arthritis or joint pains.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	0 1 2 3 4 5 6 7 8 9 10
	Swollen or red joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Gout.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Neck or back pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	0 1 2 3 4 5 6 7 8 9 10
Neuro	Common Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Frequent or severe headaches.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	0 1 2 3 4 5 6 7 8 9 10
	Seizures or Epilepsy.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Numbness or weakness in the arm or leg.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Endocrine	Take thyroid hormone	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Heat or cold intolerance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Sugar in your urine/Diabetes.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Other glandular problems.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Mental Health	Marital problems.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you been injured, or do you fear being injured by your spouse/partner	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Difficulty sleeping.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Feeling sad or depressed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Feeling nervous or anxious.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Suicidal thoughts.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Are you seeing a therapist.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Do you use illicit/illegal drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Health Maintenance: Please enter the month and year of the last time you had any of the following:

Women:	Men (over 50 years old):	All:
Pap Smear _____	Prostate blood test _____	Sigmoidoscopy (if over 50) _____
Mammogram _____		Stool Test for Blood (if over 50) _____

Do you have any additional concerns not mentioned above?

Your Signature (or person completing form): _____ Date: _____

Medical Provider Review: _____ Date: _____