

The Emory Clinic
New Patient Packet

Name: _____

Date of Birth: ___/___/___

What problem brings you here today?

Symptoms:

Onset (date)

- | | | |
|----|-------|-------------|
| 1. | _____ | ___/___/___ |
| 2. | _____ | ___/___/___ |
| 3. | _____ | ___/___/___ |
| 4. | _____ | ___/___/___ |

Personal Information:

SSN: ___-___-___

Date of Birth: ___/___/___

Age: _____

Race: Caucasian African American Asian Hispanic Other

Handedness: Right Handed Left Handed Primary Language: _____

Home Phone: ___-___-___ Work Phone: ___-___-___ Cell Phone: ___-___-___

Pharmacy: ___-___-___ Primary Caregiver: ___-___-___

Emergency Contact: ___-___-___

Primary Physician:

Who referred you to this clinic?

Name: _____

Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Fax: _____

Fax: _____

Have you been in the hospital within the last 60 days? Yes No

At this visit, the medication reconciliation form was given to the patient: Yes No (physicians only)

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Your Other Medical Problems: (Please check all that apply)

Neurological

- Stroke/TIA
- AVM
- Brain Injury at Birth
- Brain Infection
- Brain Tumor
- Traumatic Brain Injury
- Seizures w/ fever in childhood
- Developmental Delay
- Parkinson's Disease
- Tremor
- Dystonia
- Ataxia
- Hydrocephalus
- Dementia
- ALS/Lou Gehrig's
- Myasthenia Gravis
- Neuropathy
- Muscle Disease
- Spinal Cord Disease
- Multiple Sclerosis
- Migraine

- Restless Legs
 - Sleep Apnea
 - Narcolepsy
 - Optic Neuritis
 - Epilepsy
- Cardiovascular**
- Hypertension
 - High Cholesterol
 - Angina/Heart Attack
 - Arrhythmia
 - Syncope
 - Peripheral Vascular Disease
 - Heart Failure

Endocrine

- Thyroid Disease
- Osteoporosis
- Diabetes

Gastrointestinal

- Reflux/Heartburn
- Peptic Ulcer Disease
- Crohn's Disease
- Ulcerative Colitis

Cancer

- Lung
- Breast
- Brain
- Prostate
- Skin
- Colon/Rectum
- Lymphoma
- Other

Rheumatologic

- Rheumatoid Arthritis
- Lupus
- Vasculitis
- Spinal Stenosis
- Cervical Spondylosis

Hematological

- Iron Deficiency
- Sickle Cell Disease
- Anemia

Psychiatric

- Depression
- Bipolar

- Anxiety
- Panic Attack
- Schizophrenia

Respiratory

- Asthma
- Emphysema
- Tuberculosis
- Sarcoidosis

Genitourinary

- Kidney Failure
- Kidney Stones
- Prostatic Hyp.
- STD
- UTI

Surgical History:

Past Surgeries	Type	Date	Location
1.			
2.			
3.			

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4.

Your Review of Systems: (Please check if you have had any of these symptoms IN THE PAST MONTH)

Neurological

- Dizziness
- Headaches
- Muscle Pain
- Double Vision
- Droopy Eyes
- Muscle Twitching
- Weakness
- Numbness
- Tingling
- Memory Loss
- Blackouts/Seizures
- Unsteadiness
- Head Injury
- Slurred Speech
- Trouble Swallowing
- Snoring
- Daytime Sleepiness
- Insomnia
- Restless Legs
- Leg Mvmnt. During Sleep

Ocular

- Glasses
- Redness
- Dryness

Infection

ENT

- Pain/Soreness
- Discharges
- Hearing Loss
- Bleeding Gums

Hoarseness

Tinnitus

Respiratory

- Cough
- Blood in Cough
- Wheezing
- Pneumonia
- Bronchitis

Gastrointestinal

- GI Bleed
- Nausea/Vomiting
- Hepatitis
- Heartburn

Diarrhea

- Constipation
- Abdominal Pain
- Blood in Stool

Rheumatologic

- Joint Pain

Dermatologic

- Rash
- Skin Color Change
- Hair Loss
- Skin Ulcer

Constitution

- Weakness
- Tiredness
- Loss of Appetite
- Increased Appetite
- Weight Gain
- Weight Loss
- Chills
- Fever
- Night Sweats

Psychiatric

- Psychosis
- Addictions
- Anxiety
- Hallucinations
- Severe Stress
- Depression
- Mental Illness
- Mood Swings
- Phobias

Cardiovascular

- Heart Attack
- Chest Pain/Angina
- Aneurysm
- Palpitations
- Ankle Swelling
- Hand/Foot Discoloration
- Poor Circulation
- Heart Murmur
- Heart Failure

Genitourinary

- Pain with Urination
- Blood in Urine
- Urine Retention
- Urine Incontinence

Hematologic

- Easy Bruising
- Bleeding Disorder

Lymph

- Frequent Infections
- Node Enlargement

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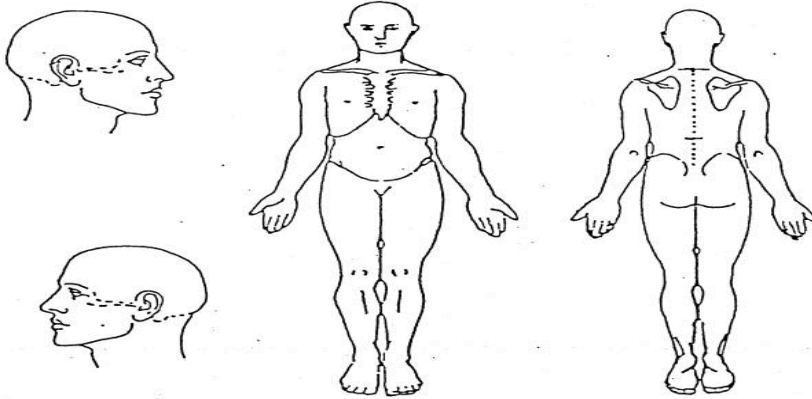
Tearing

Joint Swelling

Pain

If you have pain, numbness or tingling, please complete the following:

Please indicate with an "X" on the accompanying diagram the location of your symptoms:

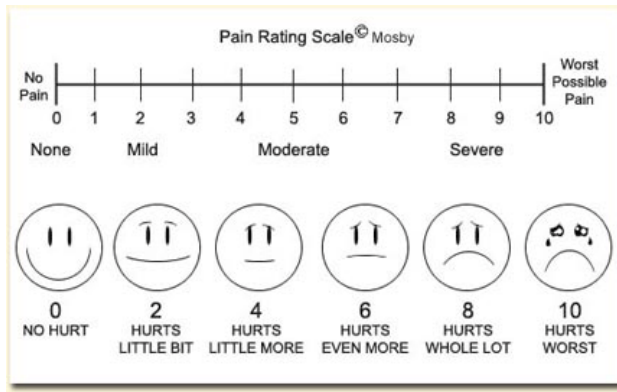


Severity: Constant Occasional Wakes you up Difficulty walking

Description: Aches Tingles Throbs

Stabbing Burns Numbness

Indicate your current pain level on the following scale:



What makes your condition worse? _____

What helps your condition? _____

Other body parts affected: _____

Symptoms affected by: _____

What kind of effect do the following symptoms have on your symptoms?

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Sitting:

Increase

Decrease

Standing:

Increase

Decrease

Exercise:

Increase

Decrease

Rest:

Increase

Decrease