

Welcome to Emory Healthcare Internal Medicine/Family Medicine at Midtown!  
To help us care for you, please provide the following information.

Name:

Date of Birth:

What is your personal and Family history? Check if any of these apply.

|                 | Heart disease | High blood pressure | Diabetes | Hyperlipidemia | Thyroid disease | Reflux | Liver disease | Kidney disease | Bleeding disorder | Sickle cell | Blood clots | Stroke | Cancer | Dementia | Lung disease |
|-----------------|---------------|---------------------|----------|----------------|-----------------|--------|---------------|----------------|-------------------|-------------|-------------|--------|--------|----------|--------------|
| Have you had?   |               |                     |          |                |                 |        |               |                |                   |             |             |        |        |          |              |
| Mother?         |               |                     |          |                |                 |        |               |                |                   |             |             |        |        |          |              |
| Father?         |               |                     |          |                |                 |        |               |                |                   |             |             |        |        |          |              |
| Brother/Sister? |               |                     |          |                |                 |        |               |                |                   |             |             |        |        |          |              |

Have you had surgery? Circle if yes.

Appendix      Gall bladder      Lung      Hernia      Heart      Thyroid      Other: \_\_\_\_\_

Social history: Please answer yes or no.

Smoke? Yes No      Drink? Yes No      Drugs? Yes No      Exercise? Yes No

Please list other doctors who take care of you.

Screening tests and immunizations: Please provide date each was done

|              |  |              |  |           |  |
|--------------|--|--------------|--|-----------|--|
| Colonoscopy  |  | Mammogram    |  | Pap smear |  |
| PSA          |  | Bone density |  | Eye exam  |  |
| Flu          |  | Pneumonia    |  | Shingles  |  |
| Tetanus/Tdap |  |              |  |           |  |

Current symptoms: Please Circle all that apply.

**General:** fever, chills, sweats, weakness, fatigue, appetite loss, weight gain, weight loss

**Eye:** recent visual problem, blurring, double vision, visual disturbance

**Ear, nose, mouth, throat:** decreased hearing, nasal congestion, sore throat, ear pain

**Respiratory:** shortness of breath, cough, sputum, hemoptysis, wheezing, apnea, snoring

**Cardiovascular:** chest pain, palpitations, leg pain with walking, swelling, passing out

**Breast:** lump, pain, nipple discharge, redness

**Genitourinary:** painful urination, blood in urine, urination at night, penial discharge from penis, incontinence

**Gastrointestinal:** nausea, vomiting, diarrhea, constipation, heartburn, abdominal pain, vomiting blood, trouble swallowing, hemorrhoids, rectal bleeding

**Gynecologic:** pain with bleeding, pain with intercourse, hot flashes, vaginal discharge

**Endocrine:** excessive thirst, cold intolerance, heat intolerance, excessive hunger

**Musculoskeletal:** back pain, joint pain, muscle pain, joint stiffness, joint swelling

**Skin:** rash, itching, burns, dryness, changing spots

**Neurological:** abnormal balance, confusion, numbness, tingling, memory loss

**Psychiatric:** anxiety, depression, decreased attention span, sleeping problems