EMORY
HEALTHCARE

Medical History

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. ______________
2. ______________
3. ______________
4. ______________
5. ______________
6. ______________
7. ______________
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
❑ Colon Cancer
❑ Other Cancer
❑ Abnormal PAP
❑ Hepatitis or Jaundice
❑ Liver/Pancreas Disease

❑ Asthma
❑ Emphysema
❑ Tuberculosis
❑ Sickle Cell
❑ Anemia
❑ Arthritis

❑ Kidney Stones
❑ Urinary Tract Infection
❑ Other Kidney Disease
❑ Seizure Disorder
❑ Received Blood Transfusion
❑ Sexually Transmitted Diseases

Other (Describe) ______________

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

❑ Appendix ______ year
❑ Hernia ______ year
❑ Tonsils ______ year

❑ Gall Bladder ______ year
❑ Heart ______ year

❑ Thyroid ______ year
❑ Lung ______ year

❑ Hysterectomy ______ year
❑ Spine/joint ______ 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.

❑ Adopted	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 immunization 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:

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

Please continue to next page.

Section	Question	Yes	No	
Genito Urinary	Get up more than once at night to urinate	❑ Yes	❑ No	
	Discomfort, burning or stinging with urination	❑ Yes	❑ No	
	Difficulty starting or stopping your urine stream	❑ Yes	❑ No	
	Kidney stone	❑ Yes	❑ No	
	Dark colored or cloudy urine	❑ Yes	❑ No	
	Leaking bladder	❑ Yes	❑ No	
Men ONLY	History of prostate trouble	❑ Yes	❑ No	
	Problems with erection/sexual difficulty	❑ Yes	❑ No	
	Penile discharge	❑ Yes	❑ No	
	Do you examine your testicles regularly	❑ Yes	❑ No	

Women ONLY

Age menses started ____________

Date of last period ____________

Number of Pregnancies____________

Births ____________

Miscarriages ____________

Abortions ____________

Method of birth control ____________

Complications of Pregnancy:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ C-section
- ❑ Toxemia
- ❑ Other: ____________

Section	Question	Yes	No	
Women ONLY	Do you examine your breasts regularly	❑ Yes	❑ No	
	Have you ever taken birth control pills	❑ Yes	❑ No	
	Have you noticed any breast lumps	❑ Yes	❑ No	
	Vaginal discharge/discomfort at present time	❑ Yes	❑ No	
	Irregular periods	❑ Yes	❑ No	
	Bleeding when not your period	❑ Yes	❑ No	
	Pain with intercourse	❑ Yes	❑ No	
	Hot flashes	❑ Yes	❑ No	
	Do you have a gynecologist:	❑ Yes	❑ No	Dr.'s Name:
Muscles/Joints	Do you have arthritis or joint pains	❑ Yes	❑ No	0 1 2 3 4 5 6 7 8 9 10
	Swollen or red joints	❑ Yes	❑ No	
	Gout	❑ Yes	❑ No	
	Neck or back pain	❑ Yes	❑ No	0 1 2 3 4 5 6 7 8 9 10
Neuro	Common Headaches	❑ Yes	❑ No	
	Frequent or severe headaches	❑ Yes	❑ No	0 1 2 3 4 5 6 7 8 9 10
	Seizures or Epilepsy	❑ Yes	❑ No	
	Numbness or weakness in the arm or leg	❑ Yes	❑ No	
Endocrine	Take thyroid hormone	❑ Yes	❑ No	
	Heat or cold intolerance	❑ Yes	❑ No	
	Sugar in your urine/Diabetes	❑ Yes	❑ No	
	Other glandular problems	❑ Yes	❑ No	
Mental Health	Marital problems	❑ Yes	❑ No	
	Have you been injured, or do you fear being injured by your spouse/partner	❑ Yes	❑ No	
	Difficulty sleeping	❑ Yes	❑ No	
	Feeling sad or depressed	❑ Yes	❑ No	
	Feeling nervous or anxious	❑ Yes	❑ No	
	Suicidal thoughts	❑ Yes	❑ No	
	Are you seeing a therapist	❑ Yes	❑ No	
	Do you use illicit/illegal drugs	❑ Yes	❑ No	

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

Women:

Pap Smear ____________

Mammogram ____________

Men (over 50 years old):

Prostate blood test ____________

All:

Sigmoidoscopy (if over 50) ____________

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: ____________