Patient Label

Initial History Form

Welcome to the Infectious Diseases Clinic of Emory Healthcare. In order for us to get to know you better and help you with any problem you might have, please fill out this health 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 at your appointment.

Name: ______________________________ Date: ____|___|_20__

Age: _______ Date of Birth: ____|___|_19___ Height: _____ inch Weight: ______ lbs

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

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

To whom do you want us to send results?
Name: ____
Address: ____
____

If we try to reach you, may we leave a message (including information related to your diagnosis?) on your voice mail/answering machine?

☐ **No** ☐ **Yes, preferred number: (____) ____ - ____ x ______**

What is your preferred way to receive lab results? Rank the ways we can contact you in order of preference.

___Mail Address: ____

___Phone Number: ____________________
This is my ___Home phone ___Work phone ___Cell phone
It is ___OK ___Not OK to leave results on the answering machine

___Email Address: ____
It is ___OK ___Not OK to email actual lab results (There are risks to confidentiality involved in electronic communications.)

Do you have a Living Will? ☐ **No** ☐ **Yes** ☐ **Don't know**

Do you have an official Medical Power of Attorney? ☐ **No** ☐ **Don't know** ☐ **Yes**

If yes, name and phone: ____

In your own words, why are you here to see an Infectious Diseases physician?

____

____

____

What medications are you taking (including vitamins, herbs, over-the-counter pills)?

Name of Drug	Dose	Taken how often?	For what purpose (diagnosis)

Have you ever had allergies to medications? ☐ No ☐ Yes

Drug	Reaction	Drug	Reaction

Please list all of your Medical problems (hypertension, diabetes, etc)

Medical Problem	When diagnosed?

Please list all of your Surgeries and Hospitalizations

Surgery, Hospitalization	Dates (approx)	Where treated?

Have you had these vaccinations?

Vaccine	Last date	Vaccine	Last date
Pneumovax		Hepatitis A	
Influenza		Hepatitis B	
Tetanus (TDAP)		Chickenpox or Shingles	

Whom do you live with? ________________________________
Who knows about your condition?________________________
Is there anyone who should not know? ____________________
Where do you live now?_________________ **Where were you born?**_______________________
Where in the US have you lived?____
____
Where have you traveled abroad? ____
____
What pets do you have?____
What was your highest grade level in school? ___________
Are you currently working? ☐ **Yes** ☐ **No**
What is/was your occupation? ____

Sexuality

Do you consider yourself? ☐ **Heterosexual** ☐ **Homosexual** ☐ **Bisexual** ☐ **Transsexual**
Are you married/committed? ☐ **Yes** ☐ **No** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**
Do you have a steady sexual partner? ☐ **Yes** ☐ **No**
Have you had sex in the past three months? ☐ **Yes** ☐ **No**
Do you use condoms? ☐ **Never** ☐ **Sometimes** ☐ **Always**
How many sexual partners have you had in the past 3 months? _______________

Substance Use

Do you smoke cigarettes? **Never** ☐ **No longer use, quit** ____ **Yes, average** _______**cigs/day**
How old were you when you started smoking? _______
Do you drink alcohol? **Never** ☐ **No longer use, quit** ____ **Yes, average** ________**drinks/day**
Did you ever have an alcohol blackout? ☐ **Yes** ☐ **No**
Did you ever have a DUI? ☐ **Yes** ☐ **No**
Do you use Marijuana? **Never** ☐ **No longer use, quit** ____ **Yes** ☐ **How often?** __________
Do you use Cocaine? **Never** ☐ **No longer use, quit** ____ **Yes** ☐ **How often?** __________
Do you use Heroin? **Never** ☐ **No longer use, quit** ____ **Yes** ☐ **How often?** __________
Do you use Crystal Meth? **Never** ☐ **No longer use, quit** ____ **Yes** ☐ **How often?** __________
Have you ever injected IV drugs? ☐ **Yes** ☐ **No**

Family History

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

Medical Condition	Check if Yes	Relative and approximate Age
High Blood Pressure		
Heart disease, MI, bypass surgery		
Hyperlipidemia (high cholesterol)		
Stroke		
Diabetes		
Cancer		
Kidney disease, dialysis		
Alzheimer's disease		
Autoimmune diseases (lupus, thyroid dis, rheumatoid arthritis, etc)		
Others		

Are you experiencing significant problems or do you have concerns with any of the following? (Room for more comments is on next page.)

No	Yes	General	Comments	No	Yes	EENT	Comments
		Weight loss				Blurred or bad vision	
		Weight gain				Spots before eyes	
		Fever or chills				Pain in eyes	
		Night sweats				Hoarseness	
		Problems with wound healing				Thrush	
		Increasing weakness, fatigue				Mouth sores	
		Dizziness				Difficulty hearing	
		Intolerance to heat or cold				Frequent nose bleeds	
		Poor appetite				Frequent sinus problems	

No	Yes	Respiratory	Comments	No	Yes	Cardiovascular	Comments
		Cough				Chest pain/discomfort	
		Wheezing/Asthma				Need to sleep head up	
		Sputum production				Irregular heartbeat	
		Shortness of breath				Fainting spell	
		Hx of exposure to tuberculosis				Swelling of feet/legs	
		Prior TB skin test (PPD)				High blood pressure	
		Hx of positive PPD				High cholesterol	
						Rheumatic heart disease	
						Heart murmur	

No	Yes	Gastrointestinal	Comments	No	Yes	Genitourinary	Comments
		Nausea/vomiting				Frequent urination	
		Vomiting blood				Painful urination	
		Blood in stools				Difficulty holding urine	
		Black/tarry stools				Decreased stream	
		Difficulty swallowing				Blood in urine	
		Indigestion/Heartburn				Penile/vaginal discharge	
		Abdominal pain				Frequent vaginal yeast	
		Diarrhea				Sores/lesions genitals	
		Constipation				Pain/masses breasts	
		Hemorrhoids				Nipple discharge	
		History of hepatitis					

No	Yes	Musculoskeletal/Skin	Comments	No	Yes	Endocrine	Comments
		Joint pain/swelling				Low thyroid (Hypo-)	
		Body ache/muscle cramps				High thyroid (Hyper-)	
		Morning stiffness				Diabetes	
		Itching				Excessive thirst	
		Rash				Change in breast size	
		Skin problems				Change in body hair	
		Easy bleeding					
		Nail problems				Decreased interest in sex	
						Problems with erection ♂	

No	Yes	Neurologic	Comments	No	Yes	Psychiatric	Comments
		Seizures				Depression	
		Headache				Anxiety	
		Tingling/numbness				Often feeling sad	
		Weakness on one side				Spontaneous crying	
		Vertigo/balance problems				Less interest in usual activities	
		Sleep disturbances				Feelings of decreased self worth	
						Hallucinations	
						Previous psychiatrist/therapist?	

Gynecologic 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 your periods regular? ☐ Yes ☐ No

Last PAP smear (MM/YY) ____/______ Date of last mammogram ____/________

Result: ____________________________ Result: _____________________________

STD history: ☐ None

Have you had any of the following? If so when were you treated?

Syphilis		Herpes simplex	
Gonorrhea		PID	
Chlamydia		Genital warts	

Is there anything else we need to know?