EMORY CLINIC

PATIENT QUESTIONNAIRE NAME_____

ADDRESS _____

_____

_____

CLINIC PHYSICIAN_____

Instructions: Please answer all questions to the best of your ability. Check all questions asking yes or no answers appropriately, but leave blank if you are not sure. Leave comments blank, these will be filled in by the physician.

A. GENERAL HEALTH (circle) Excellent Good Fair Poor

B. PAST MEDICAL HISTORY:

MEDICAL ILLNESSES	YES	NO	YEAR	COMPLICATIONS	COMMENTS
Measles (Red)					
Measles (German)					
Mumps					
Chickenpox					
Polio					
Rheumatic fever					
Pneumonia					
Tuberculosis					
Cancer					
Diabetes					
Blood Disorders					
Heart Disease					
High Blood Pressure					
Liver Disease					
Glandular Disorder					
Skin Disease					
Neurologic Disorder					
Emotional Disorder					

Primary Care Physician Name: _____

Primary Care Physician Address: _____

_____

EMORY HEALTHCARE

Primary Care Physician Telephone: _____

OHER ILLNESSES AND/OR SURGERY

(Please list illnesses or surgery, year and complications)

	Year	Complications	Comments

INJURIES:

(List all significant injuries which you can recall either in childhood or adult life with approximate date and complications)

	Year	Complications	Comments

Immunizations:

	Yes	No	Year
Small Pox			
Tetanus			
Polio			
German Measles			
Other (specific)			

EMORY
HEALTHCARE

ALLERGIES:

List all drugs or substances to which you are allergic and specify type of reaction (i.e., itching, rash, hives, wheezing, swelling, etc:

Allergy	Reaction

HABITS:

	No	Yes	How much (per day/per week)
Cigarettes			
Cigars			
Pipe			
Alcohol			
Drugs (Specify)			

MEDICATIONS: (List all medications which you now take regularly)

Medication	Amount per day

List all medications which you have taken in the past 6 months (excluding those listed above)

EMORY
HEALTHCARE

FAMILY HISTORY:

	Age	State of health (if dead, cause of death)
Father		
Mother		

Brothers	Sisters	Age	State of health (if dead, cause of death)
Children Male	Female	Age	State of health (if dead, cause of death)

Have any relatives had the following?

	No	Yes	If yes, what reaction?	Comments
Diabetes				
High Blood Pressure				
Heart Disease				
Kidney Disease				
Strokes				
Hardening of the arteries				
Arthritis or Rheumatism				
Goiter				
Cancer				
Tuberculosis				
Venereal Disease				
Seizures				

EMORY HEALTHCARE

REVIEW OF SYSTEMS: (Please check yes or no as deemed appropriate regarding the following symptoms. If you are not sure, leave blank. Leave comments blank.

No	Yes	General	Comment
		Weakness	
		Tiredness Early Morning Late Afternoon	
		Lack of appetite	
		Excess appetite	
		Weight loss	
		Weight gain	
		Chills	
		Fever	
		Night Sweats	
		Difficulty in sleeping	
No	**Yes**	**Eye, Ears, Nose, Throat**	**Comment**
		Decreased ability to see	
		Blurred vision	
		Spots before your eyes	
		Pain in the eyes	
		Infection of the eyes	
		Difficulty in hearing	
		Ringing in your ears	
		Pain in your ear	
		Discharge from the ears	
		Nose Bleeds	
		Running of the nose	
		Stuffiness of your nose	
		Sneezing	
		Post-nasal drip	
		Hay fever	
		Sore throat	
		Hoarseness	
		Pain in the neck	
		Dental trouble	
		Bleeding gums	

No	Yes	Respiratory	Comment
		Dry cough	
		Cough up phlegm	
		Cough up blood	
		Wheezing	
		Asthma	
		Shortness of breath at rest	
		Shortness of breath with exertion	
		Pain in chest when you cough, sneeze, or move	
No	**Yes**	**Cardiovascular**	**Comment**
		Chest pain, tightness or sneezing	
		Shortness of breath, lying down	
		Need to sit up to breathe	
		Heart racing	
		Irregular heart beat (palpitations)	
		Heart murmur	
		Swelling of the legs	
		Varicose Veins	
		Leg pain at rest	
		Leg pain with exertion	
		Blue or purple discoloration of hands or feet	
No	**Yes**	**Breast**	**Comment**
		Lumps	
		Pain	
		Discharge	
No	**Yes**	**Gastrointestinal**	**Comment**
		Nausea	
		Vomiting	
		Diarrhea	
		Constipation	
		Heartburn	
		Abdominal Pain	
		Bright red blood in stools	
		Black stools	
		Change in bowel habits	
		Food intolerance	
		Need for antacids	
		Hemorrhoids	

No	Yes	Urinary	Comment
		Urinary tract infections	
		Pain or burning on urination	
		Frequent urination-day	
		Frequent urination-night	
		Unusually large volumes of urine	
		Extreme urge to urinate	
		Difficulty starting urinary stream	
		Difficulty stopping urinary stream	
		Kidney stones	
No	**Yes**	**Genito-Reproductive (Male)**	**Comment**
		History of venereal disease	
		Discharge from penis	
		Testicular pain	
		Lumps in testicles or scrotum	
		Decrease in testicles size	
		Decreased sexual desire	
		Decreased ability to achieve erection	
		Genito-Reproductive (Female)	
		Age of onset of menstrual periods	
		Age which periods stopped (menopause)	
		How far apart are your periods?	
		How many days do they last?	
		Is flow heavy, scanty, or normal?	
		Do you ever bleed between periods?	
		Do you ever have to go to bed because of cramps?	
		Have you had any venereal disease? (if yes, what kind)?	
		Does intercourse cause undue pain?	
		Do you have decreased sexual desire?	
		Have you had any vaginal bleeding since menopause?	
		Are you bothered by hot flashes?	
		Are you taking any female hormones?	

EMORY HEALTHCARE

Obstetrical	Number	None	Comment
Pregnancies			
Full term deliveries			
Miscarriages			
Stillbirths			
Complications			
High blood pressure			
Toxemia			
Severe hemorrhage			
Any child over 9 lb. at birth			
Other (indicate type)			

No	Yes	Musculoskeletal	Comment
		Painful joints	
		Swelling of any joints	
		Redness of any joints	
		Stiffness of any joints	
		Deformities of the joints or extremities	
		Muscle pain	
		Back pain	
		Pain down the back of your legs	
No	**Yes**	**Endocrine**	**Comment**
		Goiter	
		Heart intolerance	
		Cold intolerance	
		Tremulousness of the hands	
		Change in pitch of the voice	
		Increased body hair (face, under arms or pubic)	
		Decrease in body hair (face, under arms or pubic)	
		Decrease in breast size	
		Loss of periods (disregard if from normal menopause)	
		Increased thirst	
		Increased urination	
		Marked increase in appetite	

No	Yes	Neurologic/Psychiatric	Comment
		Nervousness	
		Depression	
		Difficulty in going to sleep	
		Early morning awakening	
		Difficulty with memory for past events	
		Difficulty with memory for recent events	
		Difficulty with thinking or problem solving	
		Headaches	
		Blackouts	
		Dizziness	
		Double vision	
		Paralysis or weakness of a limb(s)	
		Loss of sensation	
		Loss of balance	
		Loss of coordination	
		Difficulty in speaking	
No	**Yes**	**Skin**	**Comment**
		Dryness of skin	
		Itching	
		Rash	
		Change in skin color	
		Change in texture of the hair	
		Falling out of the hair	
		Nail changes	
		Skin ulcers	