Patient History

Patient Personal History Form

emc2care™

ALPHARETTA MEDICAL ASSOCIATES

Please take time to update the following information for our files. This information is treated with strict confidentiality and will help us obtain a comprehensive assessment of your health care needs.

NAME	BIRTH DATE	DATE

CHIEF COMPLAINTS: *(Please list current symptoms)*

1	3
2	4

PAST MEDICAL HISTORY: *(Hospitalizations and Surgeries)*

REASON/DIAGNOSIS/PROCEDURE	DATE	REASON/DIAGNOSIS/PROCEDURE	DATE
	/		/
	/		/
	/		/

MEDICAL ILLNESSES OR CONDITIONS: *(Conditions you now have or have had in the past.)*

CONDITION	ONSET DATE	CONDITION	ONSET DATE	CONDITION	ONSET DATE
☐ Migraine headaches	______	☐ Stomach or duodenal ulcer	______	☐ Goiter	______
☐ Seizures of convulsions	______	☐ Hepatitis	______	☐ Gonorrhea	______
☐ Stroke	______	☐ Cirrhosis	______	☐ Syphilis or VD	______
☐ Polio	______	☐ Gall Stones	______	☐ HIV infection	______
☐ Glaucoma	______	☐ Colon or bowel trouble	______	☐ Herpes infection	______
☐ Cataracts	______	☐ Dysentary or serious diarrhea	______	☐ Chicken Pox	______
☐ Blindness	______	☐ Rectal trouble	______	☐ Mumps	______
☐ Recurrent ear infections	______	☐ Hemorrhoids	______	☐ Measles	______
☐ Deafness	______	☐ Recurrent urinary infections	______	☐ Recurrent boils	______
☐ Hay fever allergic nose	______	☐ Kidney stones	______	☐ Skin problems	______
☐ Recurrent sinusitis	______	☐ Other kidney disease	______	☐ Serious depression	______
☐ Asthma	______	☐ Arthritis	______	☐ Serious emotional problems	______
☐ Chronic bronchitis	______	☐ Gout	______	☐ Nervous breakdown	______
☐ Emphysema	______	☐ Broken bones	______	☐ Other ______	
☐ Tuberculosis	______	☐ Varicose veins	______	☐ Other ______	
☐ Heart murmur	______	☐ Phlebitis or blood clots	______	**WOMEN**	
☐ Heart attack	______	☐ Bleeding problems	______	☐ Menstrual difficulties	______
☐ Angina	______	☐ Anemia	______	☐ Abnormal PAP	______
☐ Enlarged Heart	______	☐ Cancer (Type: ______)	______	☐ Ovarian cyst(s)	______
☐ Rheumatic fever	______	☐ Diabetes	______	☐ Breast lump(s)	______
☐ High blood pressure	______	☐ Overactive thyroid	______	**MEN**	
☐ Hiatal hernia/chronic heartburn	______	☐ Underactive thyroid	______	☐ Prostate trouble	______

CURRENT MEDICATIONS: *(include non-prescription products)*

DRUG NAME	DOSE
/	
/	
/	
/	

ALLERGIES: *(include drugs, foods, chemicals, insects, etc.)*

ITEM	TYPE OF REACTION
/	
/	
/	
/	

IMMUNIZATIONS AND PREVENTIVE SERVICES: *(Check all that apply and provide date you last received each.)*

- ☐ Migraine headaches ___________
- ☐ Seizures of convulsions ___________
- ☐ Stroke ___________
- ☐ Polio ___________
- ☐ Migraine headaches ___________
- ☐ Seizures of convulsions ___________
- ☐ Stroke ___________
- ☐ Polio ___________
- ☐ Migraine headaches ___________
- ☐ Seizures of convulsions ___________
- ☐ Stroke ___________
- ☐ Polio ___________

FAMILY HISTORY: *(Please complete the following information on your relatives.)*

	Living	Dead	Age	Chronic Condition(s)/Cause of Death
Father				
Mother				
Brothers (#____) & Sisters (#____)				
Spouse				
Children (#____)				

Please check all conditions identified in your relatives and note which relatives are affected.

CONDITION	RELATION	CONDITION	RELATION	CONDITION	RELATION
☐ Migraine headaches	___________	☐ High bloof pressure	___________	☐ Bleeding problems	___________
☐ Seizures of convulsions	___________	☐ Stomach or duodenal ulcer	___________	☐ Anemia	___________
☐ Stroke	___________	☐ Liver disease	___________	☐ Sickle cell disease	___________
☐ Glaucoma	___________	☐ Gall stones	___________	☐ Cancer, including leukemia	___________
☐ Allergies	___________	☐ Colon or bowel trouble	___________	☐ Diabetes	___________
☐ Asthma	___________	☐ Kidney stones	___________	☐ Thyroid problems	___________
☐ Emphysema	___________	☐ Other kidney disease	___________	☐ Mental illness	___________
☐ Tuberculosis	___________	☐ Arthritis	___________	☐ Suicide	___________
☐ Heart Trouble	___________	☐ Gout	___________	☐ Birth defects	___________

SOCIAL/PERSONAL HISTORY: *(Please complete the following information about yourself.)*

CURRENT OCCUPATION

Education completed:

☐ Grade: _____ ☐ High School ☐ College: _____ years, degree/major ___________ ☐ Post Graduate: ______________

Marital Status:

☐ Single ☐ Married (Date: _________) ☐ Separated (Date: _________) ☐ Divorced (Date:____________) ☐ Widowed (Date: ________)

Married ________ time(s): #1: ________ yrs, ________ children #2: ________ yrs, ________ children #3: ________ yrs, ________ children

Personal Habits: (Check all that apply)

- ☐ Currently use tobacco: Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless tobacco Amount/day: ___________ Yrs: _____
- ☐ Former smoker: Amount/day: ___________ Yrs: _____ Quit Date: ______________________
- ☐ Exposed to second-hand smoke
- ☐ Consume alcohol: Type: ___________________________________ Amount/day: ______________________
- ☐ Use recreational drugs: Type: ___________________________________ Frequency: ______________________
- ☐ Consume caffeine: Beverage: ___________________________________ Amount/day: ______________________
- ☐ Exercise regularly: Type: ___________________________________ Frequency/week: ______________________
- ☐ Wear my seatbelt: Frequency (%): ___________________________________

Sexual history: ☐ Multiple sex partners ☐ Prefer opposite sex ☐ Prefer same-sex relationships

NAME | BIRTH DATE | DATE

REVIEW OF SYSTEMS: *(Please check any item which describes recent or ongoing symptoms.)*

GENERAL:
☐ *None Apply*

☐ Significant weight loss ☐ Loss of feeling of well-being ☐ Fatigue or loss of energy ☐ Difficulty sleeping

Comment: ______________________________

EYES:
☐ *None Apply*

☐ Blurred vision ☐ Double vision ☐ Spots in front of your eyes ☐ Eye pain/irritation ☐ Need for corrective lenses

Comment: ______________________________

EARS-NOSE-THROAT:
☐ *None Apply*

☐ Chronic headaches ☐ Hearing loss ☐ Ringing in ears ☐ Dizziness
☐ Chronic nasal congestion ☐ Recurring sinus infections ☐ Nose bleeds ☐ Nasal obstruction
☐ Bleeding gums ☐ Sore throat ☐ Toothache ☐ Breath odor ☐ Hoarseness

Comment: ______________________________

RESPIRATORY:
☐ *None Apply*

☐ Shortness of breath ☐ Cough ☐ Chest congestion ☐ Wheezing
☐ Coughing up blood ☐ Choking ☐ Noisy breathing ☐ History of pneumonia ☐ History of Tuberculosis (TB)

Comment: ______________________________

CARDIOVASCULAR:
☐ *None Apply*

☐ Chest pain ☐ Heart fluttering/racing ☐ Heart murmur ☐ Decreased exercise tolerance
☐ Awakening due to shortness of breath ☐ Difficulty breathing when lying down ☐ Leg swelling
☐ Pain in buttocks or legs with exercise ☐ Sensitivity of hands/feet to temperature changes

Comment: ______________________________

BREAST:
☐ *None Apply*

☐ Breast lump ☐ Breast pain ☐ Nipple discharge

Comment: ______________________________

GASTROINTESTINAL:
☐ *None Apply*

☐ Stomach pains ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Frequent heartburn ☐ Indigestion
☐ Belching/sour taste ☐ Difficulty swallowing ☐ Bloating ☐ History of hepatitis ☐ History of yellow jaundice

Rectal:

☐ Rectal bleeding ☐ Rectal pain or irritation ☐ Swelling or hemorrhoids

Comment: ______________________________

GENITOURINARY (MEN):
☐ *None Apply*

☐ Frequent Urination (☐ often at night) ☐ Frequent urge to pee ☐ Pain on urination ☐ Bloody urine
☐ Discharge from penis ☐ Trouble starting urination ☐ Interruption of urine stream ☐ Dribbling ☐ Loss of bladder control
☐ Pain or swelling of penis ☐ Pain or swelling of scrotal sac ☐ Pain or swelling in groin ☐ Decline in sexual desire
☐ Difficulting having erections or reaching climax

Comment: ______________________________

REVIEW OF SYSTEMS CONTINUED...

REVIEW OF SYSTEMS, CONTINUED: *(Please check any item which describes recent or ongoing symptoms.)*

GENITOURINARY (WOMEN):

☐ *None Apply*

☐ Frequent Urination (☐ often at night) ☐ Frequent urge to pee ☐ Pain on urination ☐ Bloody urine
☐ Frequent urinary infection ☐ Pressure in vagina ☐ Vaginal wall weakness/protrusion ☐ Frequent loss of urine
☐ Vaginal discharge ☐ Vaginal irritation ☐ Vaginal dryness ☐ Vaginal redness ☐ Vaginal pain
☐ Painful intercourse ☐ Decline in sexual desire ☐ Difficulty in sexual response ☐ Hot flashes
☐ Change in periods (menstrual flow, frequency) ☐ Mother took DES while pregnant with me
☐ Painful periods ☐ Troublesome symptoms before/during periods ☐ Other pelvic pain

Please indicate:

Number of pregnancies ______ Number of deliveries ______ Number of miscarriages/abortions ______
Age at onset of periods ______ Periods occur every _______ days and last _______ days Onset of last period ______

Comment: ____

LYMPHATIC/HEMATOLOGIC:

☐ *None Apply*

☐ Unusual lymph node swelling (in neck, arm pit, or groin) ☐ Painful lymph nodes
☐ History of anemia ☐ Blood clots ☐ Bruise easily ☐ Unusual bleeding

Comment: ____

MUSCULOSKELETAL:

☐ *None Apply*

☐ Limb or joint pains ☐ Limb or joint deformity ☐ Limb or join sweling/stiffness/redness ☐ Muscle weakness
☐ Loss of muscle bulk ☐ Muscle spasms or twitching ☐ Recurring back/neck pain ☐ Back/neck injury

Comment: ____

NEUROLOGIC:

☐ *None Apply*

☐ Seizures ☐ Tremors/shakiness ☐ Unusual clumsiness ☐ Limb weakness ☐ Numbness/tingling ☐ Stroke
☐ History of significant head injury ☐ Altered consciousness or black-outs

Comment: ____

PSYCHOLOGIC:

☐ *None Apply*

☐ Lapses in memory ☐ Periods of confusion/disorientation ☐ Difficulty concentrating ☐ Troublesome depression
☐ Worry about things ☐ Mood swings ☐ History of mental illness ☐ Unusual stress ☐ History of physical or mental abuse

Comment: ____

SKIN:

☐ *None Apply*

☐ Itching ☐ Rash ☐ Unusual dryness ☐ Changes in hair ☐ Changes in pigmentation

Comment: ____

ENDOCRINE:

☐ *None Apply*

Unexpected changes in: ☐ Tolerance to heat ☐ Tolerance to cold ☐ Unusual thirst

Comment: ____

ALLERGY/IMMUNOLOGIC:

☐ *None Apply*

☐ Seasonal allergies Sensitivity to specific items: ___________________________________
☐ Frequent or unusual infections

Comment: ____