MRN: ____________________ Date: ____________________

The Emory Clinic, Inc
Patient Questionnaire

Name			
Birth date		Age	
Occupation			

Personal Health History

Health Concerns - Describe any concerns that you would like your health care provider to address

Date	Serious Illnesses/ Hospitalizations/ Injuries/ Operations

Medications (including over the counter)	Dose	Frequency and Reason Taken	Physician	Year begun

Health Encounters	Date	Drug Allergies	Rash or Intolerance
Last Tetanus Immunization			
Pneumovax Immunization			
Influenza Immunization (Flu)			
Last Physical Exam			
Chest X-Ray			
Lab			
Electrocardiogram			
Mammogram			
Pap Smear			
Colonoscopy			

Names of Other Physicians caring for you	Specialty

Family Health History (include father, mother, sisters, brothers)

Have you or any of your family members had:	Yes	No	Unsure	Who?

High Blood Pressure or Stroke				
Heart Attack or Angina				
COPD				
Cancer (If yes, what type?)				
Seizures				
Mental Health/ Alchohol/ Drug Problems				
Diabetes				
Liver or Kidney Disease				
Other Diseases that run in your family				
Who do you live with? What are their ages and relation to you?				

Risk Assessment Your answers to the following questions will help your healthcare provider advise you about risks and your health.

	Yes	No
Do you currently smoke or use smokeless tobacco?		
Have you smoked in the past?		
If yes: How many packs per day? For how many years?		
Do you ever drink alcoholic beverages?		
If yes: Have you ever felt you ought to cut down on drinking?		
Have people criticized you about your drinking?		
Have you ever felt bad or guilty about drinking?		
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?		
Do you ever drive intoxicated or ride in a car with someone who is intoxicated?		
Number of cups of caffeinated beverages per day (coffee/tea/soda)		
Did you ever have a blood transfusion be before 1992		
Have you ever used intravenous drugs or had a sexual partner who did?		
Have you had a new sexual partner or more than one partner in the past year?		
Have you ever kept a loaded gun easily accessible in your home?		
Do you ever ride in a car without using seatbelts?		
Do you ever ride a bike without wearing a helmet?		
Do you exercise? If yes: What kind of exercise? How many times per week?		
Do you have concerns about your appearance, weight, or eating habits?		
Do you have any concerns about your sexuality?		
Do you have a living will?		
Do you have a sore that has not healed?		
Do you have unusual bleeding or discharge?		