

W. HAMLIN EMORY, M.D.

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Please Print				
Today's date:		Best contact number:		
Your last name:	First:	Middle:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status (circle one): Single / Mar / Div / Sep / Widowed / Partner
Name you like to be called:				
Street address:		Home phone: ()	Cell phone: ()	
City:		State:	ZIP Code:	Email:
Birth date: / /	Age:	Mailing Address:		
Occupation:		Employer:	Employer phone: ()	
If Student <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time				
PATIENT GUARDIAN/SPOUSE INFORMATION				
Parent / Guardian / Spouse (circle one) Full Name:	Gender: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	Address (if different):		Home phone: ()
Is this person a patient here?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
FINANCIALLY RESPONSIBLE PARTY				
Full Name:	Gender: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	Address (if different):		Home phone: ()
Is this person a patient here?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
I/We acknowledge that I/we have read, completely understand, and agree to the Office Policy. I hereby request to become a patient of W. Hamlin Emory, M.D., a Medical Corporation.				
Patient/Guardian Signature:			Date:	

Primary physician: _____ Phone Number: _____

Address: _____

Please state your major concerns or difficulties: _____

Some people's current concerns are different than those experienced in the past. Do you have a history of concerns or difficulties that are different

from those you are experiencing now? _____

At what age did you recognize the onset of your symptoms? _____

Date of first consultation for these concerns: _____

Physicians with whom you have consulted (Please include dates and duration of treatment):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Psychotherapists with whom you have consulted (Please include dates and duration of treatment):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Which medical and/or psychological treatment(s) have been helpful? Please rate the effectiveness of each treatment.

(Rating -1 to + 3; adverse = -1, none = 0, slight = + 1, modest = + 2, marked = + 3)

In what ways have you coped with your difficulty?

Has your condition affected any of the following (Please circle and explain if yes)?

Family relationships: Yes / No _____

Function at work: Yes / No _____

Social relationships: Yes / No _____

Academic performance: Yes / No _____

Please Rate the following on a scale from 0 – 10

0 = lowest rating & 10 = highest; 7-9 is a normal range

**Rate yourself WITHOUT including any extreme or unexpected life stressors. We are primarily interested in your sense of physical well-being.*

Appetite _____	Libido _____
Calm _____	Mood _____
Energy _____	Sleep _____
Focus _____	

How long does it take for you to achieve sleep?

0 – 15 min _____ 15 – 30 min _____ 30 – 60 min _____ Other _____

Once you achieve sleep, do you have difficulty remaining asleep? Yes _____ No _____

If so how many times do you wake? _____

Are you known to snore? Yes _____ No _____ Who reports your snoring? _____ To what extent do you snore? _____

Are you experiencing any physical pain?

Yes _____ No _____

If yes, please describe and **Rate on a scale from 0 – 10.**

Are you craving any substances?

Yes _____ No _____

If yes, please describe and **Rate on a scale from 0 – 10.**

How frequent is your bowel elimination? _____

Have you had any difficulty eliminating (constipation, diarrhea, etc)?

Are your thoughts faster, slower or the same rate as your speech? _____

Do you have allergies to any medication? (Circle one) Yes / No Please list: _____

List **CURRENT** medications (Please include medications prescribed by another physician, over-the-counter medications, nasal spray and vitamins/supplements.) * **Please specify GENERIC or BRAND for all medications**

<u>Name of medication</u> (i.e., Omega 3-6-9)	<u>Strength</u> (i.e., 1000 mg)	<u>Daily Dosage</u> (i.e., 2 caps/day)	<u>Rate effectiveness (-1 to +3)</u> -1=adverse, 0=none, +1=slight, +2=modest, +3=marked
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____

List **PAST** medications:

<u>Name of medication</u> (i.e., Omega 3-6-9)	<u>Strength</u> (i.e., 1000 mg)	<u>Daily Dosage</u> (i.e., 2 caps/day)	<u>Effectiveness</u> <u>Rating (-1 to +3)</u> (-1=adverse, 0=none, +1=slight, +2=modest, +3=marked)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____

Please circle your answer to the questions below:

Do you have difficulty reading a map or following trip directions?	Yes / No	Handedness: Right / Left
Do you excessively procrastinate?	Yes / No	Are you disorganized? Yes / No
Are you an excessive worrier?	Yes / No	Are you forgetful? Yes / No
Do you experience irrational fears?	Yes / No	Do you feel inferior? Yes / No
Do you often feel irritable?	Yes / No	Do you often feel jumpy? Yes / No

How often are you having suicidal thoughts presently? Frequently Sometimes Rarely Never

How often have you had suicidal thoughts in the past? Frequently Sometimes Rarely Never

When: _____

How often do you think of harming others? Frequently Sometimes Rarely Never

In the past, how often have you had thoughts of harming others? Frequently Sometimes Rarely Never

Have you ever intentionally inflicted any harm upon yourself? Yes No Unsure

When: _____

Education:

For children, current grade: _____

For adults, highest level of education completed: _____

List college and graduate experiences/degrees and dates:

Employment:

Are you currently employed (Circle)? Yes / No

If yes, are (Check all that apply): Part-Time Full-Time Temporary Permanent Self-Employed

How did you learn about the work we are doing?

Additional Comments:

Patient Signature: _____

Date: _____

Family History

	Grandmother		Grandfather		Father	Mother	Brother		Sister		Spouse/ Partner	Children	
	Paternal	Maternal	Paternal	Maternal			1	2	1	2		1	2
Age (if living)													
Age (at death)													
Cause of death													
Health (G) Good (F) Fair (P) Poor													
Alcohol Abuse													
Arthritis													
Asthma, Hives, or Hay Fever													
Blood Disease													
Cancer													
Drug Abuse													
Epilepsy													
Heart Trouble													
High Blood Pressure													
Mental Illness													
Stroke													
Tuberculosis													

Personal History

Have you ever had...	No	Yes	Have you ever had...	No	Yes	Have you ever had...	No	Yes
_ Arthritis _ Rheumatism			Anemia			Broken Bones		
_ Bone Disease			Cancer			Recurrent Dislocations		
_ Bursitis _ Joint Disease _ Sciatica			Diabetes _ Type I _ Type II			_ Concussion _ Head Injury		
Diphtheria			Seizures or Epilepsy			Food Poisoning		
Pleuritis			Frequent: _ Colds _ Sore Throats			Chemical Poisoning		
Pneumonia			Frequent: _ Infections _ Boils			Chronic Fatigue Syndrome		
_ Neuritis _ Neuralgia			_ Hay Fever _ Asthma			Latex Sensitivity		
Scarlet Fever			_ Hives _ Eczema			Any other Disease:		
Smallpox			_ High _ Low Blood Pressure			Explain:		
_ Rheumatic Fever _ Heart Disease			Migraine Headaches					
_ Polio _ Meningitis			Tinnitus (Ringing in ears)					
_ Gonorrhea _ Syphilis _ HIV			Tuberculosis					

Allergies

Are you allergic to...	No	Yes	Are you allergic to...	No	Yes	Are you allergic to...	No	Yes
_ Penicillin _ Sulfa Drugs			Any other Drugs			Any Foods		
_ Aspirin _ Codeine _ Morphine			Explain:			Explain:		
_ Antibiotics			Iodine or Radiologic Dye					
_ Tetanus _ Antitoxin			Adhesive Tape			_ Nail Polish _ Cosmetics		

Surgery

Have you had removed...	No	Yes	Have you had removed...	No	Yes	Have you...	No	Yes
Tonsils			_ Ovary _ Ovaries			Had a hernia repaired		
Appendix			Hemorrhoids			Had a Transfusion _ Blood _ Plasma		
Gall Bladder			Have you been hospitalized			Had any other operations		
Uterus			Explain:			Explain		

X-Rays

Ever had X-Rays of...	No	Yes	Ever had...	No	Yes	Have you had other tests?
Chest			Colonoscopy			Explain:
_ Stomach _ Colon			Sigmoidoscopy			
Gall Bladder			Barium Enema			
_ Extremities _ Back			Mammogram			

REVIEW OF SYSTEMS

Date of Birth:	Height:	Weight:						
Do you now have or have you ever had...			No	Yes	Do you now have or have you ever had...		No	Yes
_ Eye Disease _ Eye Injury _ Impaired Sight					Alopecia (Hair Loss)			
Tunnel Vision					Kidney: _ Disease _ Stones			
_ Ear Disease _ Ear Injury _ Impaired Hearing					Bladder Disease			
Any trouble with: _ Nose _ Sinuses _ Mouth _ Throat					Blood in Urine			
Fainting Spells					_ Protein _ Sugar _ Pus _ Other in Urine			
Convulsion(s)					Difficulty with Urination			
_ Memory Loss _ Confusion / Blurred Thinking					Narrowed Urinary Stream			
Episodes of Lapses in Time or Memory					Abnormal Thirst			
Dizziness					Prostate Trouble			
Dry Mouth					_ Stomach Trouble _ Ulcer			
Enlarged Glands					Indigestion			
Thyroid: _ Overactive _ Underactive _ Enlarged					_ Gas _ Belching			
Enlarged Goiter					Appendicitis			
Cough: _ Frequent _ Chronic					_ Liver Disease _ Gall Bladder Disease			
_ Chest Pain _ Angina Pectoris					_ Colitis _ Other Bowel Disease			
Spitting up Blood					_ Hemorrhoids _ Rectal Bleeding			
Night Sweats					Black Tarry Stools			
Episodes of Snoring					_ Any Change in Bowel Action _ Stools			
Shortness of Breath: _ Upon Exertion _ At Night					_ Constipation _ Diarrhea			
_ Fluttering Heart _ Palpitations					_ Parasites _ Worms			
Swelling of: _ Hands _ Feet _ Ankles					_ Any Change in Appetite or Eating Habits			
Frequently Cold Hands / Fingers					Explain:			
Paralysis					Change in Weight: ___ lbs lost ___ lbs gained			
Restless Legs					Nausea / Vomiting			
Burning Sensation in Feet					Extreme: _ Tiredness _ Weakness			
Headaches : _ Frequent _ Severe					Erectile Dysfunction			
Varicose Veins					Nipple Discharge			
Skin Disease					Other:			

Immunization – EKG

Have you had...	No	Yes						
Smallpox Vaccination (Within last 7 years)			No	Yes	Polio Shots (Within last 2 years)		No	Yes
Tetanus Shot (Not Antitoxin)					Influenza			
Hepatitis Vaccination					Electrocardiogram When:			
MMR (Measles, Mumps, Rubella)					Other:			

Females Only

Menstrual History...	No	Yes				
Age of Onset:			Are you Regular: _ Heavy _ Medium _ Light		No	Yes
Usual Duration of Period ___ Days			Do you have: _ Tension _ Depression Prior to Period			
Cycle (Start to Start) ___ Days			Do you have: _ Cramps _ Pain with Period			
Date of Last Period:			Do you have Hot Flashes			
Pregnancies	No	Yes				
Children Born Alive (How many ___)			Still Born (How many ___)			
Cesarean Sections (How many ___)			Miscarriages (How many ___)			
Premature (How many ___)			Any complications:			
			Explain:			

Social History

Do you...	No	Yes	Have often do you use...	Never	Occ.	Freq	Daily
Exercise: If so, how often:			Laxatives				
What type of exercise:			_ Vitamins _ Supplements				
Do you use Tobacco:			_ Aspirin _ Ibuprofen _ Aleve				
_ Cigarettes (___ packs per day)			_ Tranquilizers _ Sleeping pills				
_ Cigars _ Pipe _ Chewing Tobacco _ Snuff			Cortisone				
Do you use Other Drugs:			Alcoholic Beverages				
Do you chew gum: (___ pieces/day or ___ packs/day)			_ Diet Soda _ Energy Drinks				
Explain:			Explain:				

Nutritional Habits

Please list the foods consumed at each meal on an average day

Breakfast or 1 st meal:
Snack:
Lunch or 2 nd meal:
Snack:
Dinner or 3 rd meal:
Other:

Childhood Developmental Milestones

Parents, please list the age at which your child reached the following developmental milestones:

Physical	Social & Emotional	Intellectual	Language
Sit up on own	Developed signs of enjoyment	Aware of physical sensations	Cries vigorously
Crawl	Apprehensive towards strangers	Developed interest in surroundings	Attentive to your voice
Walk	Emotionally dependent on a familiar adult	Makes 2 – 3 word sentences	Use of 2 syllable words (ex: Mama)
Feeds self	Imitates domestic activities	Relates present and past activities	Vocalized to attract attention
Dresses self	Aware of physical needs	Shows interest in pictures	Responded to simple instructions
Build a tower of cubes	Begin imaginary play	Accurately counts to 20	Able to communicate needs
Potty trained during the daytime	Plays cooperatively with other children	Able to write own name	Able to accumulate new words rapidly
Fully potty trained	Able to cope with personal needs	Able to accurately state age	Developed sense of time
Ties own shoes	Chooses own friends	Draws with precision and detail	Talks fluently and with confidence