



Adult Medicine of Marietta, PC

790 Church Street
 Suite 250
 Marietta, GA 30060
 (678) 797-8201

PATIENT INFORMATION			
Name (Last, First, Middle)	SSN	BIRTHDATE	SEX
LOCAL ADDRESS	SECONDARY BILLING ADDRESS (IF APPLICABLE)		
CITY STATE ZIP	CITY STATE ZIP		
HOME PHONE	HOME PHONE		
PRIMARY EMPLOYER			
PRIMARY EMPLOYER	SECONDARY EMPLOYER (IF APPLICABLE)		
ADDRESS	ADDRESS		
CITY STATE ZIP	CITY STATE ZIP		
WORK PHONE	HOME PHONE		
RESPONSIBLE PARTY INFORMATION (If Different than above)			
NAME (Last First Middle)	SSN#	BIRTHDATE	SEX
LOCA ADDRESS	SECONDARY BILLING ADDRESS (If Applicable)		
CITY STATE ZIP	CITY STATE ZIP		
HOME PHONE	HOME PHONE		
RELATIONSHIP TO PATIENT			
PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY	POLICY #		
NAME OF INSURED	GROUP #		
ADDRESS OF INSURANCE COMPANY	COPAY AMT \$		
CITY STATE ZIP	DEDUCTIBLE \$		
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE	

Name: _____ Date of Birth: _____ Date: _____

Have you experienced any of the following recently:

Neuro/Psychiatric

Aphasia / language disorder	yes	no
Dysarthria/ unclear pronunciation	yes	no
Focal Weakness	yes	no
Gait disturbance / difficulty walking	yes	no
Headaches	yes	no
Incontinence	yes	no
Incoordination	yes	no
Lightheadedness / Dizziness	yes	no
Loss of consciousness / fainting	yes	no
Memory loss	yes	no
Paresthesias / tingling sensation	yes	no
Seizures	yes	no
Speech Changes	yes	no
Tremors	yes	no
Vertigo	yes	no
Visual Disturbance	yes	no
Lack of Concentration	yes	no
Do you have any anxiety?	yes	no
Do you fee fearful?	yes	no
Do you feel euphoric?	yes	no
Do you feel paranoid?	yes	no
Do you feel depressed?	yes	no
Have you been irritable recently?	yes	no
Have you felt obsessive?	yes	no
Have you been hospitalized for a mental condition?	yes	no
Do you have any thoughts of suicide?	yes	no
Have you had sleep disturbance?	yes	no
Do you have any picking habits?	yes	no
Do you feel combative?	yes	no
Do you feel unfocused?	yes	no
Are you having mood swings?	yes	no
Are you having hallucinations?	yes	no

Musculoskeletal

Back Pain	yes	no
Bone/Joint Symptoms	yes	no
Myalgias/ muscle pain	yes	no
Neck stiffness	yes	no
Deformed or swollen joints	yes	no
Weakness	yes	no

Hematologic

Do you bruise easily?	yes	no
Do you bleed easily?	yes	no
Any blood clots?	yes	no
Have you had any bleeding disorder work up performed?	yes	no
Have you a hypercoaguabililty work up performed? (due to history of blood clots)	yes	no
Cytopenia, Anemia, Low blood count	yes	no
Lymphadenopathy, swollen lymph nodes	yes	no
Petechia/ small round flat dark-red spots	yes	no

Immunological

Asthma	yes	no
Hay Fever	yes	no
Urticaria/Hives	yes	no
Severe swelling & itching	yes	no
Contact Dermatitis	yes	no
Food Allergies	yes	no
"Bee" Sting Allergies	yes	no
Environmental Allergies	yes	no
Animals at home	yes	no
Animals in work place	yes	no
Chemicals at home	yes	no
Chemicals in work place	yes	no

Dermatologic

Acne	yes	no
Contact Allergies	yes	no
Excessive sun exposure	yes	no
Frequent skin infections	yes	no
Hair loss	yes	no
Women: Facial hair	yes	no
Nail changes	yes	no
Pigment changes	yes	no
Severe itching	yes	no
Excessive sweating	yes	no
Sensitivity to light	yes	no
Rash	yes	no
Skin Lesions	yes	no

Name: _____ Date of Birth: _____ Date: _____

Have you experienced any of the following recently:

Gastrointestinal

Abdominal Mass / Growth	yes	no
Abdominal Pain	yes	no
Altered bowel habits	yes	no
Anorexia / not eating	yes	no
Black Stools	yes	no
Bloating	yes	no
Blood in Stool	yes	no
Constipation	yes	no
Diarrhea	yes	no
Dysphagia/difficulty swallowing	yes	no
Flatulence/ gas	yes	no
Coughing up blood	yes	no
Indigestion/Heartburn	yes	no
Jaundice/ yellowing	yes	no
Nausea		
Odynophagia / Painful swallowing	yes	no
Hemorrhoids	yes	no
Rectal Bleeding	yes	no
Reflux	yes	no
Vomiting	yes	no
Weight Loss	yes	no

Female / Women to complete

Age of menarche:		
Last menstrual period:		
Frequency of menses:		
Are you postmenopausal?	yes	no
Are you on hormones?	yes	no
Have you previously used hormones?	yes	no
Any nipple discharge?	yes	no
Any breast lumps?	yes	no
Any pain in your breasts?	yes	no
Do you do self breast exams?	yes	no
When was your last mammogram?		
When was your last pap smear?		
Pain with sexual intercourse?	yes	no
Any problems with fibroids?	yes	no
Have you ever had an abnormal pap?	yes	no
Any problems with infertility?	yes	no
Have you ever used birth control pills?	yes	no
Do you have a lack of libido?	yes	no
Have you had any ovarian cysts?	yes	no
Do you have any sexual dysfunction?	yes	no
Do you have any vaginal itching?	yes	no
Do you have any vaginal discharge?	yes	no

Genitourinary

Back pain	yes	no
Change in urine color	yes	no
Cloudy urine	yes	no
Decreased stream	yes	no
Dysuria/ pain when urinating	yes	no
Flank pain	yes	no
Foul urine odor	yes	no
Urinating frequently	yes	no
Groin mass	yes	no
Hematuria/ blood in urine	yes	no
Hesitancy of urination	yes	no
Incontinence	yes	no
Low urine output	yes	no
Passed a kidney stone	yes	no
Polyuria / urinating many times	yes	no
Urgency to urinate	yes	no

Metabolic / Endocrine

Any voice change?	yes	no
Any cold intolerance?	yes	no
Any heat intolerance?	yes	no
Hair loss	yes	no
Coarse Hair	yes	no
Any abnormal glucose/blood sugar tests?	yes	no
Abnormal habitus/fat distribution	yes	no
Abnormal hair distribution	yes	no
Have you been chronically overweight?	yes	no
Have you been chronically underweight?	yes	no
Clitoral enlargement	yes	no
Darkening of skin	yes	no
History of Gout	yes	no
Any excessive perspirations?	yes	no
Generalized weakness?	yes	no
Did you have gestational diabetes?	yes	no
Do you have a goiter?	yes	no
Gynecomastia/male breast enlargement	yes	no
Infertility	yes	no
Insulin reactions	yes	no
Low sugar reactions	yes	no
Numbness	yes	no
Any excessive thirst?	yes	no
Any excessive hunger?	yes	no
Excessive urination	yes	no
Tremors	yes	no
Yellowing of the skin	yes	no
Increase in size of the hands/feet	yes	no

Male / Men to complete

Are you circumcised?	yes	no
Any erectile pain?	yes	no
Any penile Discharge?	yes	no
Have you had blood in your sperm?	yes	no
Any scrotum/testicular pain?	yes	no
Any scrotum/testicular mass?	yes	no
Hydrocele / Fluid around the testis	yes	no
Do you have Herpes Genitalia?	yes	no
Any problems with infertility?	yes	no
Do you have a lack of libido/ sex drive?	yes	no
Have you been positive for a sexually transmitted disease?	yes	no
Describe your sexual function:	Normal	
	Decreased	

Name: _____ Date of Birth: _____ Date: _____

Have you experienced any of the following recently:

Constitutional

Activity change	yes	no
Chills/ Rigors	yes	no
Decreased Appetite	yes	no
Fatigue	yes	no
Fever	yes	no
Insomnia	yes	no
Irritability	yes	no
Lethargy	yes	no
Malaise / feeling unwell	yes	no
Night Sweats	yes	no
Pallor / Abnormal paleness	yes	no
Weakness	yes	no
Weight Gain	yes	no
Weight Loss	yes	no

HEENT

Headache	yes	no
Eye burning	yes	no
Diplopia / double vision	yes	no
Eye discharge	yes	no
Eye dryness	yes	no
Foreign Body sensation	yes	no
Eye Itching	yes	no
Nystagmus / rapid eye movement	yes	no
Eye Pain	yes	no
Photophobia	yes	no
Eye Redness	yes	no
Scotoma	yes	no
Spots / Floaters	yes	no
Tearing	yes	no
Glasses	yes	no
Contacts	yes	no
Visual Loss:	yes	no
Radial Keratotomy	yes	no
Lasik	yes	no
Last eye exam:		
Ear Discharge	yes	no
Cerumen / Ear wax	yes	no
Ear Fullness	yes	no
Hearing Loss	yes	no
Ear Infections	yes	no
Noise Exposure	yes	no
Ear Pain	yes	no
Tinnitus / ringing in the ears	yes	no
Vertigo / dizziness	yes	no

Nose & Sinus

Decreased Smell	yes	no
Nasal Discharge	yes	no
Epistaxis/ nose bleeds	yes	no
Facial Pain	yes	no
Infections	yes	no
Nasal Congestion	yes	no
Obstruction	yes	no
Rhinorrhea/watery discharge	yes	no
Sneezing	yes	no

Throat & Mouth

Taste Change	yes	no
Voice Change	yes	no
Cold Sores	yes	no
Dysphagia / difficulty swallowing	yes	no
Hoarseness	yes	no
Lump	yes	no
Pain behind the sternum with swallowing	yes	no
Post nasal drip	yes	no
Sore tongue	yes	no
Sore Throat	yes	no
Snoring	yes	no
Tooth Pain	yes	no

Respiratory/Thorax

Accelerated Respirations	yes	no
Cough	yes	no
Chest Pain	yes	no
Cyanosis / blueing	yes	no
Frequent respiratory infections	yes	no
Coughing blood	yes	no
Known TB exposure	yes	no
Positive PPD/ TB test	yes	no
Pleuritic Pain	yes	no
Snoring	yes	no
Shortness of Breath	yes	no
Sputum	yes	no
Stridor - louder & harsher than wheezing	yes	no
Use of Accessory Muscles for respirations	yes	no
Wheezing	yes	no

Cardiovascular

Chest Pain	yes	no
Shortness of breath	yes	no
Short of breath on exertion	yes	no
orthopnea/ sleeps sitting up	yes	no
Shortness of breath at night	yes	no
Swelling	yes	no
Nighttime urination	yes	no
Palpitations	yes	no
Syncope/ passed out	yes	no

Vascular

Numbness	yes	no
Claudication/cramping pain	yes	no
Cyanosis/Blueing	yes	no
Erythema/flushing	yes	no
Cool extremities	yes	no
Edema/ Swelling	yes	no
Pain	yes	no
Ulcers	yes	no
Raynaud's	yes	no
Varicose veins	yes	no
Thrombophlebitis /swelling after blood clot	yes	no

Name: _____ Date of Birth: _____ Date: _____

When was the last time you had.... Date

Cholesterol checked	
Colonoscopy	
Flexible sigmoidoscopy	
Stool cards / FOBT	

Women:

Mammogram	
Breast exam by a nurse/doctor	
Papsmear	

Men:

Prostate blood test / PSA	
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Flu / Influenza vaccine	
Pneumonia vaccine	
Tetanus (Td) vaccine	

Bone Density	
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Hepatitis A vaccine	
Hepatitis B vaccine	
PPD test/Tuberculosis test	
MMR - Measles/Mumps/Rubella	

SOCIAL HISTORY

Name: _____ Date of Birth: _____ Date: _____

Birthplace: _____

Last level of education completed: _____

Current status: single married divorced widowed

Do you live alone: yes no

Previously widowed: yes no _____ times

Previously divorced: yes no _____ times

Children: yes no Number of Sons: Number of Daughters:

Smoker: yes no former Passive smoke exposure? yes no

type: _____ packs per day: _____ years smoked: _____ year quit: _____

Have you ever tried to quit? yes no

Do you drink caffeine? yes no

Type: Coffee Tea Soda Amount per day: _____

Do you drink alcohol? yes no formerly

Type: _____ Frequency: _____ Amount: _____

When was your last drink? _____

Activity level: sedentary moderate vigorous

Are you a health club member? now previously never

What type of exercise do you do? _____

How frequently are you exercising? _____

How many hours a week do you spend exercising? _____

List your hobbies: _____

Are you following a specific type of diet? _____

low fat low carb weight watchers sugar busters vegetarian

Any animals in the home? yes no Type: _____

Any recent travel out of the state? yes no Where: _____

Any recent travel out of the country? yes no Where: _____

What type of home heating do you have? gas electric solar

Do you have smoke detectors in your home? yes no

Do you have carbon monoxide detectors in your home? yes no

Have you had radon in your home? yes no treated untreated

Do you have firearms at home? yes no

Do you use a seat belt? yes no

Do you have any advanced directives?

None DNR Living Will Durable Power of Attorney HC Proxy

Do you agree to transfusions? yes no

Name: _____ Date of Birth: _____ Date: _____

FAMILY HISTORY

Please list all family members including mother, father, sisters, brothers.

Check here if adopted

Family Member	Name	Medical Problems/ Diagnosis	Age	Deceased
Mother				
Father				

SURGICAL HISTORY

Please list all surgeries or procedures you have had.

Date	Type of Surgical Procedure or Hospitalization	Reason for surgery or Hospitalization	Hospital	Name of Surgeon

List all other specialists you are currently seeing:

PATIENT INFORMATION

Name (Last, First, Middle)	BIRTHDATE
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SECONDARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY #	
NAME OF INSURED	GROUP #	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	\$
CITY STATE ZIP	DEDUCTIBLE	\$
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

I do hereby assign all medical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all my charges not paid by my insurance. I acknowledge that no assurance or promises have been given the patient concerning the results, which may be obtained by such treatments and procedures hereby, affirmed by the signature of the undersigned.

SIGNATURE OF PATIENT/GUARDIAN

DATE