Greater Athens Physicians, Inc.

Date:_____

Patient Name:_____
DOB:_____
Phone number:_____

Do we see any family member (please list names)?

What physician have you been seeing?

Do you have insurance? What kind?

What medications are you currently taking?

Are you allergic to any medications?

Do you have chronic conditions/problems? If yes, please list?

Is the whole family going to become patients with our practice?

Why are you changing doctors?

Are you sick now?

Referred by:_____

Doctor approval: Yes_____ No_____

PERSONAL HISTORY FORM

NAME:_____

DOB:_____

When was your last Tetanus booster?_____

Have you had the Pneumonia shot?	Yes	No	When?_____
Do you take the flu shot?	Yes	No	When?_____
Have you had the shingles shot? (60 and over)	Yes	No	When?_____

REVIEW OF SYSTEMS

Please circle any item that describes recent or ongoing symptoms.

GENERAL:

Unexplained weight loss/gain, chronic fatigue, change in appetite, night sweats, fever, chills, difficulty sleeping

EYES:

Blurred vision, double vision, spots in front of your eyes, floaters, eye pain/irritation, redness, excessive tearing, eye discharge, loss of vision, need for glasses/contacts, color blindness, glaucoma, cataracts, decrease in vision

When was your last eye exam?_____

EARS/NOSE/THROAT

Hearing loss, ringing in ears, chronic nasal congestion, allergies, nose bleeds, nasal obstruction, recurrent sinus infections, bleeding gums, sore throat, chronic hoarseness, toothache, bad breath, ruptured ear drum, snoring,

RESPIRATORY

Shortness of breath, cough, coughing up blood, wheezing, choking, noisy breathing, history of pneumonia, history of tuberculosis (TB), pain with breathing, shortness of breath with activity

CARDIOVASCULAR

Chest pain with exertion, chest pain or pressure, heart fluttering/racing, heart murmur, decreased exercise tolerance, awakening due to shortness of breath, difficulty breathing when lying down, leg swelling, calf pain with exercise, sensitivity of hands/feet to temperature changes, high blood pressure, phlebitis, varicose veins, stroke, rheumatic fever, blood clots, high cholesterol/triglycerides

BREAST

Breast lump, breast pain, nipple discharge, skin changes

GASTROINTESTINAL

Stomach pain, nausea, vomiting, diarrhea, constipation, frequent heartburn, indigestion, belching/sour taste, difficulty swallowing, food hanging up, bloating, history of hepatitis, black bowel movements, blood in stools, decreased appetite, sense of filling up quickly, ulcer disease, fatty food intolerance, vomited blood, dairy intolerance, colon polyps, hemorrhoids

GENITOURINARY (MEN)
Frequent urination, Urge to urinate, pain with urination, blood in urine, hesitancy with urination, nighttime urination, interruption of stream, loss of bladder control, dribbling, pain or swelling of penis, pain or swelling of scrotal sac, pain or swelling in groin, testicular pain or swelling, decline in sexual desire, difficulty having erections or reaching climax, kidney stones, prostate infections, sexually transmitted infections

GENITOURINARY (WOMEN)
Frequent urination, frequent urge to urinate, pain with urination, bloody urine, frequent urinary infections, 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, painful periods, pelvic pain, troublesome symptoms before/during periods

When did your periods start?_____ When did your periods stop?_____
Number of pregnancies?_____ Number of miscarriages/abortions?_____
How long do your periods usually last?_____ Are your periods regular?_____

MUSCULOSKELETAL
Limb or joint pains, limb or joint stiffness/swelling/redness, muscle weakness, muscle cramps/spasms/twitching, loss of muscle bulk, recurring back/neck pain, back/neck injury, gout, arthritis

DERMATOLOGY
Skin rash, skin cancer, shingles, skin sores that won't heal, unusual moles, mouth sores that won't heal, skin or toenail fungus, psoriasis, itching, unusual dryness,

NEUROLOGIC
Seizures, tremors/shakiness, unusual clumsiness, limb weakness, numbness/tingling, stroke or stroke like symptoms, history of concussion/head injury, altered consciousness or black-outs
Vertigo, dizziness, loss of consciousness, frequent headaches, memory problems, restless leg symptoms, jerking/thrashing during sleep

NEUROPSYCHIATRIC
Difficulty sleeping, depression, anxiety, thoughts of suicide, nervous breakdown, thoughts of hurting someone else, rage, irritability, anger, excessive worries, psychiatric /psychological counseling

ENDOCRINE
Unexpected changes in: tolerance to heat/cold, excessive thirst, excessive hunger, excessive urination, thyroid disease, high blood sugar, hypoglycemia, diabetes,

HEMATOLOGY
Anemia, bleeding disorder, previous blood transfusion, enlarged or swollen lymph nodes, blood clots, easy bruising, unusual bleeding

Do you have a living will or durable power of attorney for healthcare? Yes No

Family History:

Name (PLEASE Print First and Last)	Age	Living	Deceased	Medical Problems
Father				
Mother				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Brother				
Brother				
Brother				
Brother				
Sister				
Sister				
Sister				
Sister				
Child				
Child				
Child				
Child				

Activities of Daily Living: Are you able to do the following things:

1. Bath Yourself	Yes	No
2. Groom Yourself	Yes	No
3. Dress Yourself	Yes	No
4. Prepare your own meals	Yes	No
5. Feed Yourself	Yes	No
6. Take/manage your own meds	Yes	No
7. Do light housework	Yes	No
8. Do heavy housework	Yes	No
9. Do yard work	Yes	No
10. Transfer / change positions	Yes	No
11. Walk without assistance	Yes	No
12. Shop for yourself	Yes	No
13. Manage your own finances	Yes	No
14. Bowel Management	Yes	No
15. Urination management	Yes	No

PATIENT MEDICAL HISTORY

Check if you personally have had any of the following:

Asthma __	Arthritis __	Anemia __	Bursitis __
Back Injury __	Cancer __ (if yes, what type_____ and when _____)		
Diabetes __	Epilepsy __	Scarlet Fever __	Polio __
Rheumatic Fever __	Meningitis __	Pneumonia __	Gonorrhea/Syphilis __
Tuberculosis __	Neuritis __	Skin Disorder __	Frequent Infections __
Migraines __	Psychiatric Treatment __		High Blood Pressure __
Head/Neck Injury __	Other _____		

Family History:

Cancer (who and what) _____

Diabetes _____

Heart Disease _____

Other _____

Allergies to Medications (please list if any) _____

_____

Surgical History: (year and type)_____

_____

_____

Current Medications: (prescribed and over the counter): _____

_____

_____

_____

_____

Use Tobacco: YES NO How much?_____

Use Alcohol: YES NO How much?_____

Use Coffee: YES NO How much?_____

Women Only:

Are you currently having periods? Yes No

At what age did your periods begin? _____ How often ____(days) How long ___(days)

Did you suffer from cramps? No Yes, how severe _____ (1-10 scale)

Year of last period (if stopped)_____

Are you troubled by hot flashes? No Yes, how severe _____ (1-10 scale)

Prenancy: Times pregnant _____ No. of full term ___ No. of premature ____

No. Living now _____ No. miscarriages/abortions ____