PEACHTREE DUNWOODY Medical Associates

Name: _____

Date of Birth _____ Age_____ Marital Status S M W Sep Div

Address _____ City _____ State _____ Zip_____

Phone: Home _____ Work _____ Cell _____

Occupation _____

Briefly list your current medical symptoms: _____

_____

_____

_____

_____

Current Medications:

Allergies: _____

Past Medical History: (please circle)

High Blood Pressure	Heart Disease	Kidney Disease
High Cholesterol	Stroke	Asthma
Diabetes	Cancer	Clotting disorder
Thyroid Disease	Arthritis	Osteoporosis

Other: _____

Past Surgical History

MEDICAL HISTORY

PEACHTREE DUNWOODY Medical Associates

Name: _____

Date of Birth _____

REVIEW OF SYSTEMS: (Please verify if you have had any of the following within the last 30 days)

DATE _____

General	**YES**	**NO**
Weight Change >10 lbs	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Difficulty Sleeping	☐	☐
Blood Transfusion	☐	☐
Head and Neck	**YES**	**NO**
Visual Changes (Not Glasses)	☐	☐
Dizziness	☐	☐
Double Vision	☐	☐
Sinus Problems	☐	☐
Frequent Persistent Nosebleeds	☐	☐
Ear Pain	☐	☐
Trouble Hearing	☐	☐
Ringing In Ears	☐	☐
Hoarseness	☐	☐
Persistent Sore Throat	☐	☐
Mouth Sores	☐	☐
Swollen Glands (Frequent)	☐	☐
Ear Drainage	☐	☐
Hearing Loss	☐	☐
Respiratory/Lungs	**YES**	**NO**
Stop Breathing During Sleep	☐	☐
Shortness Of Breath	☐	☐
Coughing Up Blood	☐	☐
Wheezing	☐	☐
Cough	☐	☐
Sore Throat	☐	☐
Sleep Apnea	☐	☐
Snoring	☐	☐
Heart/Vascular	**YES**	**NO**
Chest Pain/Tightness	☐	☐
Irregular Rapid Heartbeat	☐	☐
Smothering Feeling At Night	☐	☐
Ankle Swelling	☐	☐
Stomach/Bowel	**YES**	**NO**
Black/Bloody Stools	☐	☐
Nausea/Vomiting (Frequent)	☐	☐
Frequent Heartburn/Acid (GERD)	☐	☐
Abdominal Pain	☐	☐
Diarrhea (Frequent)	☐	☐
Constipation	☐	☐
Difficulty Swallowing	☐	☐
Vomiting Blood	☐	☐
Kidney/Bladder	**YES**	**NO**
Urinary Tract Infection	☐	☐
Urinary Incontinence	☐	☐
Urinary Hesitancy	☐	☐
Frequent Urination	☐	☐
Urinary Urgency	☐	☐
Frequent Nightime Urination	☐	☐
Painful Urination	☐	☐
Blood in urine	☐	☐
Urinary Retention	☐	☐
Painful Urination/Dysuria	☐	☐
Foul Smelling Urination/UTI	☐	☐

Reproduction	**YES**	**NO**
Blood In Semen/Sperm (Men)	☐	☐
Inability To Have An Erection	☐	☐
Inability To Reach Climax	☐	☐
Infertility	☐	☐
Painful Intercourse	☐	☐
Decreased Sexual Desire	☐	☐
Sexually Transmitted Diseases	☐	☐
Women	**YES**	**NO**
Breast Pain/Lumps	☐	☐
Pelvic Pain	☐	☐
Vaginal Discharge	☐	☐
Vaginal Dryness	☐	☐
Frequent Sweats/Hot Flashes	☐	☐
Menstrual Problems	☐	☐
Menopause	☐	☐
Pregnancy Problems	☐	☐
Baby Weighing 9 lbs Or More	☐	☐
Skeletal	**YES**	**NO**
Gout	☐	☐
Back Pain (Major)	☐	☐
Neck Pain (Major)	☐	☐
Weakness Of Arm Or Leg	☐	☐
Joints Swelling/Stiffness	☐	☐
Deformities Of Back/Extremeties	☐	☐
Back Pain	☐	☐
Left Leg Pain/Numbness/Tingling	☐	☐
Right Leg Pain/Numbness/Tingling	☐	☐
Left Arm Pain/Numbness/Tingling	☐	☐
Right Arm Pain/Numbness/Tingling	☐	☐
Neuro	**YES**	**NO**
Numbness Or Tingling	☐	☐
Severe Frequent Headaches	☐	☐
Abnormal Coordination	☐	☐
Trouble With Speech	☐	☐
Forgetfulness/Confusion	☐	☐
Weakness Of Arm Or Leg	☐	☐
Headache	☐	☐
Skin And Hair Problems	**YES**	**NO**
Changes In Hair/Hair Loss	☐	☐
Major Skin Problems	☐	☐
Wounds That Will Not Heal	☐	☐
Persistent Rash	☐	☐
Changes In Moles	☐	☐
Endocrine	**YES**	**NO**
Heat Intolerance	☐	☐
Cold Intolerance	☐	☐
Psych/Social	**YES**	**NO**
Feeling blue/Discouraged	☐	☐
High Anxiety/Stress	☐	☐
Loss Of Friends	☐	☐
Feeling life has no purpose	☐	☐
Feeling others are talking about you	☐	☐
Feeling Fear	☐	☐
Hearing Voices	☐	☐
Marital Or Relationship Problems	☐	☐
Early Morning Awakenings	☐	☐
Insomnia	☐	☐

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