

**INFECTIOUS DISEASE SERVICES OF GEORGIA, P.C.**  
**ROSWELL • CUMMING • JOHNS CREEK**

**COMPREHENSIVE PATIENT HISTORY**

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date: \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

**Describe the following:**

Location: \_\_\_\_\_ How long have you had this problem? \_\_\_\_\_

How severe is this problem?  mild  moderate  very How often are you having the problem? \_\_\_\_\_

What caused the problem? \_\_\_\_\_

Do you know of anything else that may have contributed to this problem? \_\_\_\_\_

Does anything else occur with this problem? \_\_\_\_\_

**Provider Comments:**  I have confirmed the above information with the patient and the following are any additional comments: \_\_\_\_\_

List previous hospitalizations/Surgeries/Serious Injuries:	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Patient Social History**

Marital Status:  Single  Married  Separated  Divorced  Widowed

Describe Current Tobacco Use:  Current Every Day Smoker  Current Some Day Smoker  Smoker – Current Status Unknown  
 Former Smoker  Never Smoker  Unknown if Ever Smoked

Describe Alcohol Use:  Never Use  Monthly Use or Less  2 to 4 Times per Month  
 2 to 3 Times per Week  4 or More Times per Week  Daily Use

Use of Drugs:  Never Use Identify Drug or Drugs Used: \_\_\_\_\_  
 Monthly Use or Less  2 to 4 Times per Month  2 to 3 Times per Week  4 or More Times per Week  Daily Use

Excessive Exposure At Home or Work To:  Fumes  Dust  Solvents  Noise

Have you ever had the following?		Diabetes.....		yes	no	Hypertension.....		yes	no
Cancer.....	yes	no	Stroke.....	yes	no	Heart trouble.....	yes	no	
Arthritis/Gout.....	yes	no	Convulsions.....	yes	no	Bleeding Tendency.....	yes	no	
Acute Infections.....	yes	no	Venereal Disease.....	yes	no	Hereditary Defects.....	yes	no	

**Family Medical History**

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

**Current Medication**

List all medication that you are currently taking – including “OVER-THE-COUNTER” [OTC] medication(s).  
Request additional paper if needed to complete list.

Medication	Check One	Dosage and Frequency	Reason Taken	(If Prescription Medication) Prescribed by
	Prescription <input type="checkbox"/> OTC <input type="checkbox"/>			
	Prescription <input type="checkbox"/> OTC <input type="checkbox"/>			
	Prescription <input type="checkbox"/> OTC <input type="checkbox"/>			
	Prescription <input type="checkbox"/> OTC <input type="checkbox"/>			
	Prescription <input type="checkbox"/> OTC <input type="checkbox"/>			
	Prescription <input type="checkbox"/> OTC <input type="checkbox"/>			
	Prescription <input type="checkbox"/> OTC <input type="checkbox"/>			
	Prescription <input type="checkbox"/> OTC <input type="checkbox"/>			
	Prescription <input type="checkbox"/> OTC <input type="checkbox"/>			
	Prescription <input type="checkbox"/> OTC <input type="checkbox"/>			
	Prescription <input type="checkbox"/> OTC <input type="checkbox"/>			
	Prescription <input type="checkbox"/> OTC <input type="checkbox"/>			
	Prescription <input type="checkbox"/> OTC <input type="checkbox"/>			
	Prescription <input type="checkbox"/> OTC <input type="checkbox"/>			
	Prescription <input type="checkbox"/> OTC <input type="checkbox"/>			
	Prescription <input type="checkbox"/> OTC <input type="checkbox"/>			

**Medication Allergies**

Have you ever had an allergic reaction to medication:  Yes  No  Check if allergic to more than 8 meds

If “yes” -- List all medications and describe the allergic reaction you experienced below.

Name of Medication :

Describe Reaction:

- |          |       |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |
| 6. _____ | _____ |

**Other Allergies**

List any OTHER allergies that you have:

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

**Have you recently experienced any of the following?**

**PLEASE ANSWER ALL QUESTIONS**

**CONSTITUTIONAL** **Date**

Good general health lately.....	No	Yes
Recent weight change.....	No	Yes
Fever.....	No	Yes
Fatigue.....	No	Yes
Headaches.....	No	Yes

**EYES**

Eye disease or injury.....	No	Yes
Wear glasses/contact lens.....	No	Yes
Blurred or double vision.....	No	Yes
Glaucoma.....	No	Yes

**ENT**

Hearing loss.....	No	Yes
Ringings in the ears.....	No	Yes
Earaches or drainage.....	No	Yes
Sinus problems.....	No	Yes
Nose bleeds.....	No	Yes
Mouth sores.....	No	Yes
Bleeding gums.....	No	Yes
Bad breath or bad taste.....	No	Yes
Sore throat or voice change.....	No	Yes
Swollen glands in neck.....	No	Yes

**CARDIOVASCULAR**

Heart trouble.....	No	Yes
Chest pains.....	No	Yes
Sudden heart beat changes.....	No	Yes
Swelling of feet, ankles or hands.....	No	Yes

**RESPIRATORY**

Frequent coughing.....	No	Yes
Spitting up blood.....	No	Yes
Shortness of breath.....	No	Yes
Asthma or wheezing.....	No	Yes

**GASTROINTESTINAL**

Loss of appetite.....	No	Yes
Change in bowel movements.....	No	Yes
Nausea or vomiting.....	No	Yes
Frequent diarrhea.....	No	Yes
Painful bowel movements or constipation.....	No	Yes
Blood in stool.....	No	Yes
Stomach pain.....	No	Yes

**GENITOURINARY**

Frequent urination.....	No	Yes
Burning or painful urination.....	No	Yes
Blood in urine.....	No	Yes
Change of force of strain when urinating.....	No	Yes
Incontinence or dribbling.....	No	Yes
Kidney stones.....	No	Yes
Male – testicle pain.....	No	Yes
Female – pain with periods.....	No	Yes
Female – irregular periods.....	No	Yes
Female – vaginal discharge.....	No	Yes
Female – # pregnancies _____ # miscarriages _____		
Female – date of last pap smear _____		
Female – findings of last pap smear <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		

**MUSCULOSKELETAL** **Date**

Joint pain.....	No	Yes
Joint stiffness or swelling.....	No	Yes
Weakness of muscles or joints.....	No	Yes
Muscle pain or cramps.....	No	Yes
Back pain.....	No	Yes
Cold extremities.....	No	Yes
Difficulty in walking.....	No	Yes

**SKIN**

Rash or itching.....	No	Yes
Change in skin color.....	No	Yes
Change in hair or nails.....	No	Yes
Varicose veins.....	No	Yes
Breast pain.....	No	Yes
Breast lump.....	No	Yes
Breast discharge.....	No	Yes

**NEUROLOGICAL**

Frequent or recurring headaches.....	No	Yes
Light headed or dizzy.....	No	Yes
Convulsions or seizures.....	No	Yes
Numbness or tingling sensations.....	No	Yes
Tremors.....	No	Yes
Paralysis.....	No	Yes
Stroke.....	No	Yes

**PSYCHIATRIC**

Memory loss or confusion.....	No	Yes
Nervousness.....	No	Yes
Depression.....	No	Yes
Sleep problems.....	No	Yes

**ENDOCRINE**

Glandular or hormone problem.....	No	Yes
Thyroid disease.....	No	Yes
Excessive thirst or urination.....	No	Yes
Heat or cold intolerance.....	No	Yes
Dry skin.....	No	Yes
Change in hat or glove size.....	No	Yes

**HEMATOLOGIC/LYMPHATIC**

Slow to heal after cuts.....	No	Yes
Easily bruise or bleed.....	No	Yes
Anemia.....	No	Yes
Phlebitis.....	No	Yes
Past transfusion.....	No	Yes
Enlarged glands.....	No	Yes

History was filled out by other than patient. Print Name and relationship: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

I have reviewed and confirmed this information with the patient.

Provider Signature: \_\_\_\_\_