



THE EMORY CLINIC, INC.
DEPARTMENT OF NEUROLOGY

1365 Clifton Road, N.E., Atlanta GA 30329
Phone 404/778-3444 Fax 404/778-3745
Appointments 404/778-3444

New Patient Information Questionnaire

Name: _____ Date of Birth: _____ SSN: _____ Race: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: (h) _____ (w) _____ (cell) _____

Marital Status: M S D W Handedness: Right Left Ambidextrous

Employment Status: _____ Primary Occupation: _____

Years of Education: _____ Degree(s) Earned: _____

Family Contact:

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: (h) _____ (w) _____ (cell) _____

Emergency Contact:

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: (h) _____ (w) _____ (cell) _____

Primary Caregiver (if other than Family Contact)

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: (h) _____ (w) _____ (cell) _____

ADVANCED DIRECTIVES

Have you executed any of the following documents?

- | | | |
|--|------------------------------|-----------------------------|
| Durable Power of Attorney for HEALTHCARE | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| *Living Will | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Durable Power of Attorney for FINANCES | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

*A living will is a document that states how aggressive you want medical care near the end of your life. A living will is NOT your "Last Will & Testament" they are different.

REFERRING PHYSICIAN(S)

Name: Dr. _____

Address: _____

Office #: _____ Fax #: _____

Please appropriate box.

Yes, send my records to this doctor.

No, don't send my records to this doctor.

Name: Dr. _____

Address: _____

Office #: _____ Fax #: _____

Please appropriate box.

Yes, send my records to this doctor.

No, don't send my records to this doctor.

I acknowledge that the above information may include that which is otherwise privileged or confidential by law (including, but not limited to information regarding treatment for mental illness, mental retardation, and alcohol or substance abuse, communications with psychiatrists and psychologists, and information regarding assessment of risk, counseling, testing and test results, diagnosis or treatment for Acquired Immunodeficiency Syndrome (AIDS); AIDS related complex, HIV (human immunodeficiency virus) infection or any other disease). I expressly waive any physician-patient, psychiatrist-patient, and psychologist-patient privilege with respect to any information that may be contained in the records identified above.

I hereby release The Emory Clinic, Inc., and other agents and employees, from any and all liabilities, responsibilities, damages, losses, claims, and expenses which may arise from the obtaining or release of information authorized above.

I acknowledge that this Consent to Disclosure of Information is valid for a period of ninety (90) days from the date signed by patient or the patient's legally authorized representative. I understand that I may revoke this consent at any time, except where disclosure has already been made on the basis of this consent.

I acknowledge that I have read or have had read to me and fully understand the above statements, and expressly and voluntarily consent to the disclosure of the information to the individual or agency named above.

Patient's Name: _____

Signature of Patient: _____

Today's date: _____

Date of Birth: _____

SSN# or Drivers License # _____

Medical Record Number: _____

*Signature of Patient's Representative: _____

Today's date: _____

Relationship to Patient: _____

Witness Signature: _____

NOTICE TO RECEIVING AGENCY

IF MEDICAL INFORMATION IS SUBJECTED TO FEDERAL CONFIDENTIALITY RULES 42 CFR PART 2
 This information has been disclosed to you from information protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules protect you from making any further disclosure of this information unless further disclosure is expressly permitted by 42CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict the use of the information to criminally investigate or prosecute any drug or alcohol abuse patient.

Note: Attending Medical Doctor must approve the release of data to patient or patient's representative.

***PLEASE RECORD SPECIAL CIRCUMSTANCES WHICH NECESSITATE SIGNATURE BY PATIENTS REPRESENTATIVE**

HISTORY OF PRESENT ILLNESS:

Please describe your main problem:

When did the symptoms begin?

How did the symptoms begin? (e.g. gradually, suddenly, intermittently)

Have things progressed? If yes, how?

Has anything helped or worsened the symptoms? If yes, what?

What tests have already been performed? (e.g. MRI, CT scan) What were the results if known?

SOCIAL HISTORY:

Smoking: pack per day: _____ Prior smoking habits: _____

Alcohol: approximate drinks per week: _____

Spouse's education: _____ Spouse's health: Good Fair Poor

Does your spouse or significant other work? _____

Who is home during the day to help out if needed? _____

Are other family members and/or close friends nearby or involved in helping? _____

Are there significant financial problems or concerns?

PAST MEDICAL HISTORY:

Please list any serious medical problems, illnesses or accidents since childhood (i.e., high blood pressure, diabetes, heart attack, ulcers, asthma, cataracts, learning disability, etc.) or any other problem(s) you feel is significant.

PROBLEM:

DATE:

Pregnancies, Miscarriages, Abortions?

PAST SURGICAL HISTORY:

DATE:

ALLERGIES:

Are you allergic to any medication(s)? If yes, please list them.

Do you have any other allergies? If yes, please list them.

CURRENT MEDICATIONS:

Please list all medications you are currently taking.

MEDICATION:

DOSAGE/TIME TAKEN:

Please list other medications you have previously tried for your neurologic problem.

MEDICATION:

DOSAGE/TIME TAKEN:

REVIEW OF SYSTEMS:

Have you recently had any of the following symptoms? Please ✓ the appropriate box.

	YES	NO
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
Increased appetite	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Poor vision	<input type="checkbox"/>	<input type="checkbox"/>
Do you require glasses?	<input type="checkbox"/>	<input type="checkbox"/>
Pain in eyes	<input type="checkbox"/>	<input type="checkbox"/>
Infection of eyes	<input type="checkbox"/>	<input type="checkbox"/>
Pain in ears	<input type="checkbox"/>	<input type="checkbox"/>
Ear discharge	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Pain in neck	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain, tightness or squeezing	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath lying down	<input type="checkbox"/>	<input type="checkbox"/>
Heart racing	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations or irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Calf/leg pain at rest	<input type="checkbox"/>	<input type="checkbox"/>
Calf/leg pain on walking	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of the ankles or legs	<input type="checkbox"/>	<input type="checkbox"/>
Purplish discoloration of hands/feet	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>
Pain or burning on urination	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Usually large volumes of urine	<input type="checkbox"/>	<input type="checkbox"/>
Unable to control urine accidents	<input type="checkbox"/>	<input type="checkbox"/>
Extreme urge to urinate	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain/swelling or redness	<input type="checkbox"/>	<input type="checkbox"/>
Deformities of any joints	<input type="checkbox"/>	<input type="checkbox"/>

REVIEW OF SYSTEMS:

Have you recently had any of the following symptoms? Please ✓ the appropriate box.

	YES	NO
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Pain down the back of legs	<input type="checkbox"/>	<input type="checkbox"/>
Goiter	<input type="checkbox"/>	<input type="checkbox"/>
Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Increased thirst	<input type="checkbox"/>	<input type="checkbox"/>
Changes in body hair (face, under arms or pubic)	<input type="checkbox"/>	<input type="checkbox"/>
Dry cough	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath at rest	<input type="checkbox"/>	<input type="checkbox"/>
History of venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sexual desire	<input type="checkbox"/>	<input type="checkbox"/>
Increased sexual interest/desire	<input type="checkbox"/>	<input type="checkbox"/>
Discharge from penis	<input type="checkbox"/>	<input type="checkbox"/>
Decreased ability to achieve erection	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Breast lumps or discharge	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty chewing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Bright red blood in stools	<input type="checkbox"/>	<input type="checkbox"/>
Black stools	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Change in skin color	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>
Skin ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>
Easy bleeding or bruising	<input type="checkbox"/>	<input type="checkbox"/>
Swollen lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGICAL SYMPTOMS: Please circle ONLY ONE answer for each question.	
Do you have more trouble remembering things that have happened recently (e.g., asking the same questions/repeating the same thing over and over)?	NOT AT ALL MILD SEVERE
When speaking, do you have more difficulty in finding the right word or tend to use the wrong words more often?	NOT AT ALL MILD SEVERE
Are you less able to manage money and financial affairs (e.g., paying bills, budgeting)?	NOT AT ALL MILD SEVERE
Are you less able to manage your medications independently?	NOT AT ALL MILD SEVERE
Are you depressed?	NOT AT ALL MILD SEVERE
Have you had sudden, short episodes of unconsciousness, memory problems, or confusion?	YES NO
Have you had sudden, short episodes of jerking, falling, or other abnormal movement?	YES NO
Did you have seizures or convulsions as a child?	YES NO
Do you have any blood relatives who have had seizures or convulsions?	YES NO
Do you have difficulty with big movements like walking or getting up from a chair?	YES NO
Do you have difficulty with fine or small movements like fastening buttons or handwriting?	YES NO
Do you have abnormal movements that you cannot control?	YES NO
Do you have problems with posture or balance?	YES NO

NEUROLOGICAL SYMPTOMS: Please circle ONLY ONE answer for each question.			
Have you ever had a sudden painless weakness on one side of your body?	YES	NO	UNKNOWN
Have you ever had a sudden numbness or a "dead feeling" on one side of your body?	YES	NO	UNKNOWN
Have you ever had sudden, painless loss of vision in one or both eyes or double vision?	YES	NO	UNKNOWN
Have you ever had sudden dizziness or imbalance that was not caused by an inner ear problem?	YES	NO	UNKNOWN
Have you ever suddenly lost the ability to understand what people were saying?	YES	NO	UNKNOWN
Have you ever suddenly lost the ability to express yourself verbally or in writing?	YES	NO	UNKNOWN
Have you fallen to the ground in the last year?	YES	NO	
Have you experienced vertigo (sense of rotation) with nausea in the last year? If so, how many times?	YES	NO	FREQUENCY _____