MEDICAL ASSOCIATES of NORTH GEORGIA

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320 Hospital Road, Canton GA 30114
770-479-5535 • Fax 770-479-8821

Patient Information

Patient Name: _____ Date of Birth: _____

Allergies & Reactions to Medications: _____

_____

Please list all current medications: _____

_____

_____

Pharmacy Name: _____ Pharmacy Phone: _____

Family History

Has anyone in your family (blood relatives) had any of the following? (Please check all boxes that apply.)

	Father	Mother	Siblings	Children	Grandparents
Diabetes	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Blood Disorders	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Drug or Alcohol Addiction	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Cancer (please give details)	☐	☐	☐	☐	☐

_____

_____

Social History:

Marital Status: Single Married Divorced Widowed

Occupation: _____

Hobbies: _____

Please circle and fill in blanks if applicable

Use of Alcohol: Never Rarely Moderately Daily

Use of Tobacco: Never Yes, if yes please answer the following

Type of Tobacco: Cigarettes Snuff Chewing Tobacco Currently _____ packs/day
Previously, but quit (when) _____ packs/day.

MEDICAL HISTORY QUESTIONNAIRE

Medical History:

Have you ever had or been diagnosed to have: *(check box by all that apply)*

Diabetes		Hepatitis		Arthritis		Blood Disorders		Colon Polyps		Major Depression	
High Blood Pressure		Liver Disease		Joint Pain/Swelling		Thyroid Disease		Ulcers		Anxiety	
Heart failure		Anemia		Kidney Disease		Seizures		Swollen Ankles/Legs		Head Trauma	
Heart Attack		Intestinal Disease		Kidney Stone(s)		Cancer (type)		Lupus		Back Problems	
Irregular Heartbeat		Blood in Stool		Emphysema		Skin Disease		HIV Positive		Shock	
Stroke		Diarrhea		Pneumonia		Migraines		Drug or Alcohol Abuse			
Asthma		Constipation		Persistent Cough		Sinus Problems		Chronic Allergies			

Review of Systems: Have you had any of the following problems recently? *(check box by all that apply)*

Hearing Loss		Ear Pain/Drainage		Ringing in Ears		Mouth Ulcers		Bruising of Skin	
Vision Changes		Nose Bleeds		Allergies/Hay Fever		Bleeding Gums		Memory Loss	
Hoarseness		Eye Pain		Headaches		Difficulty Urinating		Confusion	
Balance Problems		Dizziness		Chest Pain		Painful Urination		Lack of Concentration	
Cough		Swollen Glands		Irregular Heartbeat		Blood in Urine			
Wheezing		Blood in Stool		Joint Pain		Difficulty Urinating			
Nausea/Vomiting		Back Problems		Muscles Cramps		Skin Rash			
Abdominal Pain		Constipation		Numbness/Tingling		Itchy/Flaky Skin			
Shortness of Breath		Diarrhea		Sore Throat		Dry Skin			

Please list all surgeries: _____

_____

_____

Medications: (list all medications you are taking regularly: Include over the counter, herbal or natural remedies.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Pt's Signature: _____ **Staff's Signature:** _____ **RN,LPN,MA**

Date: _____ **Date:** _____

MEDICAL HISTORY QUESTIONNAIRE