EMORY CLINIC

Dear Patient,

Thank you for choosing Emory Genetics. Your health is very important to us, and we want to make your visit as easy as possible.

All the information that you will need for your appointment is in this packet: date, time, phone numbers, directions, patient registration form and medical questionnaire. Please review the enclosed information thoroughly, and complete the registration form and the questionnaires included prior to your visit.

During your clinic visit, you can expect three main activities:

- Registration: you will sign in, your insurance and registration information will be processed, and co-payments will be collected.
- Examination: your height and weight will be taken by a nurse, and then you will see your physician.
- Checkout: your visit will be processed, and follow-up appointments will be scheduled.

We hope that your clinic visit is a positive experience for you. Please contact the Department of Human Genetics at 404-778-8570 if you have any questions prior to your visit. We look forward to seeing you soon.

Sincerely,

The Physicians and Staff of Emory Genetics

1365 Clifton RD., Building B, Suite 2200 • Atlanta, Georgia 30322
Tel 404.778.8570 • Fax 404.778.8562

Version 12302016

EMORY CLINIC

APPOINTMENT INFORMATION:

Date: _____ Time: _____

Dr. _____ Specialty: Genetics

Location: Emory Clinic
Department of Human Genetics
1365 Clifton Road
Building B, Suite 2200
Atlanta, Georgia 30322

The following items should be completed before your visit:

1. **You are responsible** for having all physicians including your referring physician, specialty physicians, and/or medical facilities, send all pertinent medical records (especially lab results, copies of x-ray reports, etc.) to us **so that we receive them at least two weeks prior to your appointment.** All records can be faxed to the Department of Human Genetics at 404-778-8562 or mailed to us at the address provided.

2. Complete the medical history questionnaire form and return to us **at least two weeks prior to your appointment**. Our mailing address is:

   Emory Clinic
   Department of Human Genetics
   Attn: Adult Clinic
   1365 Clifton Road
   Building B, Suite 2200
   Atlanta, Georgia 30322

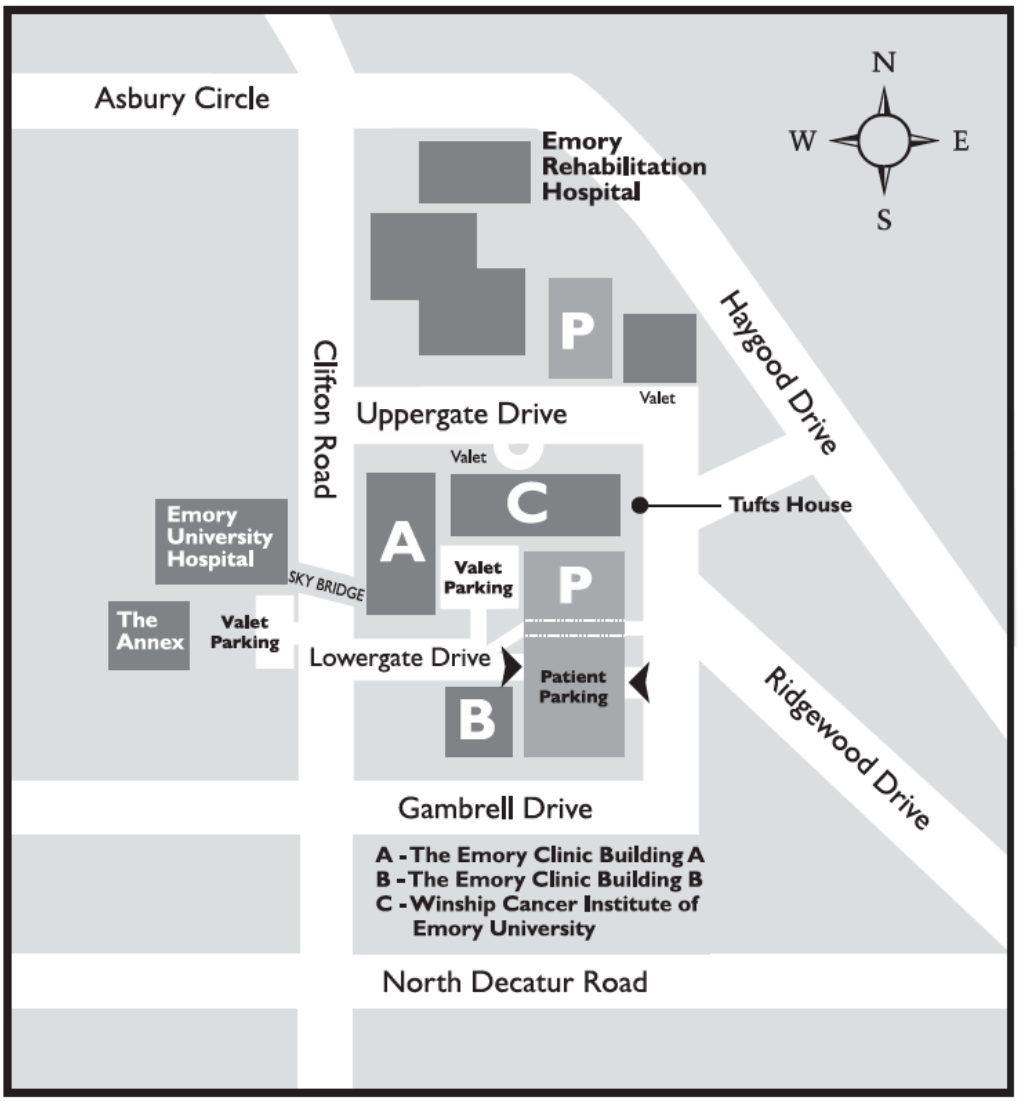
Please bring the following to your clinic visit:

1. Your completed registration form.
2. Your insurance card.

Important: Please allow for an extra 15-20 minutes before your appointment for parking. Fees for parking range from $4 to $8 depending on your length of stay. Valet parking is a flat rate of $8.**We ask that you arrive at clinic at least 30 minutes before your scheduled appointment time to allow for proper registration and processing of your insurance. Patients arriving late may not be able to see a physician and may need to be re-scheduled.**

If you are unable to keep a scheduled appointment, please notify us as soon as possible. We maintain a waiting list of patients who need specialized attention. Patients missing more than two appointments without proper cancellation (at least 24 hours prior to appointment time) will be dismissed and not rescheduled. **If you have any questions regarding your appointment, or to reschedule or cancel your appointment, please call the Department of Human Genetics at 404-778-8570.**

EMORY CLINIC



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Department of Human Genetics

PATIENT REGISTRATION FORM

PATIENT INFORMATION			
Name:			
Address:			
City, State, Zip:			
Home Telephone: ( )			
Date of Birth: Sex: M F Social Security #:			
PARENTAL / BILLING INFORMATION (When the patient is a minor)			
	MOTHER'S INFORMATION	FATHER'S INFORMATION	LEGAL GUARDIAN'S INFORMATION
Name:			
Address:			
City, State, Zip:			
Home Telephone:	( )	( )	( )
Social Security #:			
Date of Birth:			
Employer:			
Employer's Address:			
City, State, Zip:			
Work Telephone:	( )	( )	( )
With whom does the patient reside? (**Circle one**) Mother Father Legal Guardian			
Language (if not English): Other – please specify:			

Referred By:
Physician _____ Specialty _____
Address _____ City_____ State _____ Zip _____
Telephone (__)_____ Pre-cert #_____

Primary Care Physician:
Name: _____ Phone: _____
Address: _____
Chief Complaint (Reason for Visit): _____
Please provide insurance information below:

MEDICAID
Insured's Name:
_____ Medicaid # (include letters):

Please check one:
- GBHC # _____
- HMO _____
- Family Plus _____
- American _____
- Other _____

INSURANCE POLICY NO. 1
Insured's Name:
_____
ID # (include letters):
_____
Group # or Name:_____
Ins. Co. Name:
_____
Address for Mailing Claims:_____
_____

INSURANCE POLICY NO. 2
Insured's Name:
_____
ID # (include letters):
_____
Group # or Name:_____
Ins. Co. Name:
_____
Address for Mailing Claims:_____
_____

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Department of Human Genetics

ADULT GENETICS
PATIENT QUESTIONNAIRE

NAME: _____

ADDRESS: _____

PHONE: _____ **BIRTHDATE:** _____

Instructions: Please answer all questions to the best of your ability.
Check all questions asking for *yes* or *no* answers appropriately, but leave blank if you are not sure. Leave Comments blank as these will be filled in by the physician.

GENERALHEALTH (circle) Excellent Good Fair Poor

If you answered "fair" or "Poor", please explain:

PAST MEDICAL HISTORY

MEDICAL ILLNESSES	YES	NO	YEAR	COMPLICATIONS	COMMENTS
Cancer					
Diabetes					
Blood disorders					
Heart disease					
High blood pressure					
Liver disease					
Glandular disorders					
Skin disease					
Neurologic disorders					
Emotional disorders					

Any other illnesses you have had:

SURGERY (list any surgery you have had)

	Year	Complications	Comments

MEDICATIONS (list all medications which you now take regularly)

Medication	Amount per Day

ALLERGIES: (list all drugs or substances to which you are allergic and specify type of reaction [i.e. itching, rash, hives, wheezing, swelling, etc])

Allergy	Reaction

EMORY CLINIC

Department of Human Genetics

PLEASE CHECK ANY OF THE FOLLOWING THAT MIGHT BE IN YOUR FAMILY:

- ☐ Anencephaly (open skull)
- ☐ Arthritis or rheumatism
- ☐ Blindness or eye problems
- ☐ Bone disorder
- ☐ Cancer Type _____
- ☐ Cerebral palsy
- ☐ Chromosome abnormality
- ☐ Cleft lip/palate
- ☐ Cystic fibrosis
- ☐ Deafness
- ☐ Down syndrome (mongolism)
- ☐ Epilepsy or seizures
- ☐ Female Breast Cancer
- ☐ Goiter
- ☐ Hardening of the arteries (early age)
- ☐ Heart defect
- ☐ Hemophilia (bleeding tendency)
- ☐ High blood pressure
- ☐ Hydrocephalus (water on brain)
- ☐ Immunity problems (allergy)
- ☐ Infertility
- ☐ Kidney disease
- ☐ Limb defects
- ☐ Male breast cancer
- ☐ Malformations or birth defects
- ☐ Mental illness or retardation
- ☐ Metabolic problem
- ☐ Muscular dystrophy
- ☐ Neurofibromatosis
- ☐ Neurologic or degenerative disorder
- ☐ Seizures
- ☐ Short stature (under 5 ft)
- ☐ Sickle cell anemia
- ☐ Skeletal problems (like easily broken bones or curvature of the spine)
- ☐ Skin disease (including dark or light patches of skin)
- ☐ Spina bifida (open spine)
- ☐ Strokes
- ☐ Tall stature (above 6'1")
- ☐ Urinary tract abnormality
- ☐ Other _____
- ☐ None of the above

Indicate relationship of affected family member to you.

_____

_____

_____

_____

REVIEW OF SYSTEMS: Please check *yes* and *no* as deemed appropriate regarding the following symptoms. If you are not sure, leave blank. Leave comments blank.

No	Yes	General	Comments
		Weakness	
		Tiredness Early morning Late afternoon	
		Lack of appetite	
		Excess appetite	
		Weight loss	
		Weight gain	
		Chills	
		Fever	
		Night sweats	
		Difficulty in sleeping	

No	Yes	Eyes, Ears, Nose, Throat	Comments
		Decreased ability to see	
		Blurred vision	
		Spots before your eyes	
		Infection of the eyes	
		Difficulty in hearing	
		Ringing in your ears	
		Pain in your ears	
		Discharge from the ears	
		Nosebleeds	
		Running of the nose	
		Stuffiness of your nose	
		Sneezing	
		Post-nasal drip	
		Sinus trouble	
		Hay fever	
		Sore throat	
		Hoarseness	
		Pain in the neck	
		Dental trouble	
		Bleeding gums	

No	Yes	Respiratory	Comments
		Dry cough	
		Cough up phlegm	
		Cough up blood	
		Wheezing	
		Asthma	

No	Yes	Respiratory	Comments
		Shortness of breath at rest	
		Shortness of breath at exertion	
		Pain in the chest when you cough, sneeze or move.	

No	Yes	Cardiovascular	Comments
		Chest pain, tightness or squeezing	
		Shortness of breath lying down	
		Need to sit up to breathe	
		Heart racing	
		Irregular heart beat (palpitations)	
		Heart murmur	
		Swelling of the legs	
		Varicose veins	
		Leg pain at rest	
		Leg pain when exertion	
		Blue or purple discoloration of hands or feet	

No	Yes	Breasts	Comments
		Lumps	
		Pain	
		Discharge	

No	Yes	Gastrointestinal	Comments
		Nausea	
		Vomiting	
		Diarrhea	
		Constipation	
		Heartburn	
		Abdominal pain	
		Bright red blood in stools	
		Black stools	
		Change in bowel habits	
		Food intolerance	
		Need for antacids	
		Hemorrhoids	

No	Yes	Urinary	Comments
		Urinary tract infections	
		Pain or burning on urination	
		Frequent urination – day	
		Frequent urination – night	
		Unusually large volumes of urine	
		Extreme urge to urinate	
		Difficulty starting urinary stream	
		Difficulty stopping urinary stream	
		Kidney stones	

No	Yes	Genito-Reproductive (Male)	Comments
		History of venereal disease	
		Discharge from penis	
		Testicular pain	
		Lumps in testicles or scrotum	
		Decrease in testicular size	
		Decreased sexual desire	
		Decreased ability to achieve erection	

No	Yes	Genito-Reproductive Female)	Comments
		Age of onset of menstrual periods	
		Age which periods stopped (menopause)	
		How far apart are your periods?	
		How many days do they last?	
		Is flow heavy, scanty or normal?	
		Do you ever bleed between periods?	
		Do you ever have to go to bed because of:	
		When was date of your last normal period?	
		When was date of the last period before that?	
		Do you ever have heavy vaginal discharge?	
		Have you had any venereal disease? (If yes, what kind?)	
		Does intercourse cause undue pain?	
		Do you have decreased sexual desire?	
		Have you had any vaginal bleeding since	
		Are you bothered by hot flashes?	
		Are you taking any female hormones?	

Obstetrical	Number	None	Comment
Pregnancies			
Full term deliveries			
Miscarriages			
Stillbirths			
Complications			
High blood pressure			
Toxemia			
Severe hemorrhage			
Any children over 9 lb. at birth			
Other (indicate type)			
Any children under 5 lbs at birth			

No	Yes	Musculoskeletal	Comments
		Painful joints	
		Swelling of any joints	
		Redness of any joints	
		Stiffness of any joints	
		Deformities of the joints or extremities	
		Muscle pain	
		Back pain	
		Pain down the back of your legs	

No	Yes	Endocrine	Comments
		Goiter	
		Heat intolerance	
		Cold intolerance	
		Tremulousness of the hands	
		Change in pitch of the voice	
		Increased body hair (face, under arms or pubic)	
		Decreased body hair (face, underarms or pubic)	
		Decrease in breast size	
		Loss of periods (disregard if from normal menopause)	
		Increased thirst	
		Increased urination	
		Marked increase in appetite	

No	Yes	Neurologic/Psychiatric	Comments
		Nervousness	
		Depression	
		Difficulty in going to sleep	
		Early morning awakening	
		Difficulty with memory for past events	
		Difficulty with memory for recent events	

No	Yes	Neurologic/Psychiatric Cont.	Comments
		Difficulty with thinking or problem solving	
		Headaches	
		Blackouts	
		Dizziness	
		Double vision	
		Paralysis or weakness of a limb(s)	
		Loss of sensation	
		Loss of balance	
		Loss of coordination	
		Difficulty in speaking	

No	Yes	Skin	Comments
		Dryness of skin	
		Itching	
		Rash	
		Change in skin color	
		Change in texture of the hair	
		Falling out of the hair	
		Nail changes	
		Skin ulcers	

REFERRING PHYSICIAN:

NAME: _____

ADDRESS: _____

_____

_____

_____

PHONE: (_____) _____

PRIMARY CARE PHYSICIAN:

NAME: _____

ADDRESS: _____

_____

_____

_____

PHONE: (_____) _____

Patient Name: _____ *Date of birth:* _____

Please complete all sections and return to Medical Genetics two weeks prior to your visit. If you need additional space, use the backs of the pages and indicate which section (A, B, C, D) is being supplemented.

SECTION A: PATIENT INFORMATION

Patient name: _____ Birthdate: __/__/__ Sex: M___F___.___

Has the patient ever been known by any other name(s)? If **yes,** what name(s):_____.__

SECTION B: PATIENT'S SISTERS AND BROTHERS

Please list--include miscarriages of the patient's mother. Indicate "**S**" for sisters/brothers with the **Same** two parents, "**M**" for sisters/brothers who have only the same **Mother** as the patient, or "**F**" for sisters/brothers who have only the same **Father** as the patient. Use back of page if needed.

Name	S/M/F	Age	Sex	# of children	Living, or approximate age at death	Abnormalities (if any) or cause of death (Also note death or any abnormalities of the children of these individuals)
					Yes No	
					Yes No	
					Yes No	
					Yes No	

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Patient Name: _____ *Date of birth:* _____

SECTION C: PATIENT'S PARENTS AND THEIR SISTERS AND BROTHERS, i.e. THE AUNTS AND UNCLES OF THE PATIENT

Indicate "**S**" for sisters/brothers with the **Same** two parents, "**M**" for sisters/brothers who have only the same **Mother**, or "**F**" for sisters/brothers who have only the same father.

Name	S/M/F	Age	Sex	# of children	Living, or approximate age at death	Abnormalities (if any) or cause of death (Also note death or any abnormalities of the children of these individuals)
Patient's mother			F		Yes No	
					Yes No	
					Yes No	
					Yes No	
					Yes No	

Patient's father			M		Yes No	
					Yes No	
					Yes No	
					Yes No	
					Yes No	

Patient Name: _____ *Date of birth:* _____

SECTION D: PATIENT'S GRANDPARENTS

Name	Age	Sex	# of children	Living, or approximate age at death	Abnormalities (if any) or cause of death
Mother's father		M		Yes No	
Mother's mother		F		Yes No	

Name	Age	Sex	# of children	Living, or approximate age at death	Abnormalities (if any) or cause of death
Father's father		M		Yes No	
Father's mother		F		Yes No	