Ryan T. Bunch, DO
Andrew Ferris, DO
Brad Freidinger, MD
Brockford Damon Herring, DO
Smiresh Suresh Shah, MD
Shane Casey Tipton, MD
Marc Ward, MD

***Piedmont Orthopedic Specialists***

Joshua Colombo, PA-C
David Drago, PA-C
Robert Marshall Ramsey, PA-C
Elizabeth Cortney Schlegelmilch, PA-C
Robert Lewis Schwartz, PA-C
Gregory F. Shea, PA-C
Chris Stavenger, PA-C
Kristin E. Sung, PA-C
Rhiannon Turner, PA-C

# Medical History Questionnaire

Patient Name: ______________________________ Referring Physician: ______________________________
DOB: ______________________________
Gender (circle): Male Female Age: __________ Reason for Visit: ______________________________
Height: ______________ Weight: ______________

## PAST MEDICAL HISTORY

**ALLERGIES**: ____________________________________________

*Do you currently or have you ever had any of the following:* NO YES (circle all that apply)

| | | | | |
|---|---|---|---|---|
| Diabetes | High Blood Pressure | Heart Disease | Seizure Disorder | Ulcer |
| Sleep Apnea | Stroke | Heart Attack | Asthma | Cancer |
| Emphysema | Phlebitis/Blood Clots | Bleeding Disorder | Fibromyalgia | Thyroid Disease |
| Depression/Anxiety | Gout | GERD/Reflux | Osteoarthritis | Kidney Stones |
| Rheumatoid Arthritis | Hepatitis | High Cholesterol | Complications from Anesthesia | |

List any other conditions not mentioned above: ____________________________________________

____________________________________________

***If all of your medications have been prescribed by providers within Atrium Health, just write "See System" in box below.***

| *Medication* | *Dose* | *Medication* | *Dose* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| ***List ALL surgeries or hospital procedures:*** | |
|---|---|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

## FAMILY HISTORY

❐ No family history of any of the medical problems listed below.

Please circle any significant health problems in your family history *and* please list the relationship to patient:

Heart Disease / ______________________________ Diabetes / ______________________________
High Blood Pressure / ______________________________ Cancer / ______________________________
Stroke / ______________________________ Rheumatoid Arthritis / ______________________________
Other: ____________________________________________

## SOCIAL HISTORY

Alcohol Use: (type / frequency / amount) ______________________________
Nicotine Use (circle): Smoke / Vape / Chew (amount and years used) ______________________________
Occupation: ______________________________ Employer: ______________________________

***PLEASE COMPLETE BOTH SIDES OF THIS FORM***

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**REVIEW OF SYSTEMS**

❒ ALL below systems have been reviewed and ALL are NEGATIVE, excluding chief complaint.

*(Please write NONE beside any items that do not apply)*

**Constitutional:** Fever, sudden weight loss/gain, loss of appetite: ______________________________

**Eyes:** Blurred vision, double vision, difficulty seeing: ______________________________

**Ear/Nose/Throat:** Deafness, sinusitis, hoarseness, vertigo, tinnitus: ______________________________

**Cardiovascular:** Chest pain, palpitations, irregular heartbeat, murmur: ______________________________

**Respiratory:** Shortness of breath, wheezing, chronic cough, spitting blood: ______________________________

**Digestive:** Abdominal pain, constipation, diarrhea, bleeding: ______________________________

**Urologic:** Pain when urinating, hesitancy, bleeding, incontinence: ______________________________

**Gynecologic:** Breast masses, pain, discharge problems: ______________________________

**Skin:** Rashes, lesions that do not heal, changes in moles: ______________________________

**Neurological:** Seizures, loss of balance/coordination, paralysis, loss of memory: ______________________________

**Endocrine:** Excessive thirst, excessive urination, intolerance to heat/cold: ______________________________

**Blood and Lymphatic System:** Anemia, bleeding tendencies, swollen nodes: ______________________________

**Allergic and Immunologic:** Hives, eczema, itching: ______________________________

**Musculoskeletal:** Stiffness, joint pain, muscle wasting: ______________________________

**Other:** ______________________________

______________________________

______________________________

______________________________

Patient Signature: ______________________________ Date: ______________________________

Provider Signature: ______________________________ Date: ______________________________

***PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS FORM***