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 David Drago, PA-C
 Robert Marshall Ramsey, PA-C
 Elizabeth Cortney Schlegelmilch, 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) _____
 Tobacco (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