Ryan Bunch, DO
Brad Freidinger, MD
Brockford Herring, DO
Smiresh Shah, MD
Marc Ward, MD
Andrew Ferris, DO

Atrium Health
Piedmont Orthopedic Specialists

Greg Shea, PA-C
Dave Drago, PA-C
Stacy Henrickson, NP
Josh Colombo, PA-C
Chris Stavenger, PA-C
Rhiannon Turner, PA-C
Kristin Sung, PA-C

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ Referring Physician: _____
DOB: _____
Gender (circle): Male Female Age: _____ Reason for visit: _____
Height: _____ Weight: _____

PAST MEDICAL HISTORY

Do you currently or have you ever had any of the following: NO YES (circle all the 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	Complication from Anesthesia		High Cholesterol

List any other conditions not mentioned above: _____

If all of your medications have been prescribed by providers within Atrium Health System just write SEE SYSTEM in box below.

Medication	Dose	Medication	Dose

List ALL Surgeries or hospital procedures:	
1	4
2	5
3	6

ALLERGIES: _____

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/_____Other: _____
High Blood Pressure/_____Cancer/_____
Stroke/_____Rheumatoid Arthritis_____

SOCIAL HISTORY

Alcohol use (type and 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, spiting 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 MAKE SURE TO COMPLETE BOTH SIDES OF THIS FORM

Updated:7/9/2019