Piedmont Orthopedic Specialists

Dr. Ryan Bunch
Dr. Andrew Ferris
Dr. Brad Freidinger
Dr. Brockford Herring
Dr. Smiresh Shah
Dr. Marc Ward

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ Referring Physician: _____
DOB: _____ SSN: _____
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 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	Complication from Anesthesia	High Cholesterol	

List any other conditions not mentioned above: _____
_____
_____

Medication	Dose	Medication	Dose
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

ALLERGIES: _____

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:

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, 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:** _____

Physician Signature: _____ **Date:** _____

PLEASE MAKE SURE TO COMPLETE BOTH SIDES OF THIS FORM