RADIOLOGY ASSOCIATES OF ATLANTA
PIEDMONT RADIOLOGY

Date ______________________________ Marital Status S M D W

Name ______________________________ Home # ____________________

Address ______________________________ Cell # ____________________

City ______________ State ________ Zip ________ Work # ____________________

Social Security # ______________________________ Date of Birth ____________________

1. **Who Referred You to Our Office?**

Name ____

Address ____

2. **How did you hear about Radiology Associates of Atlanta?**

ف Brochure ف Folio ف Newspaper ف Radio ف TV
ف Yellow Pages ف Internet ف Friend ف Other ____________________

3. Height ______________________________ Weight ______________________________

4. What is your diagnosis and when were you diagnosed with it(fibroids, fracture, cirrhosis, cancer, etc)?
____

5. When did your current symptoms begin? ______________________________

6. **Describe current symptoms (uterine fibroid patients only):**
Menorrhagia (heavy bleeding, clots) ____________ Urinary Frequency (urgency) ____________
Getting up at night # of times ____________ Bloating ____________
Constipation ____________ Painful Intercourse____________
Pelvic Pain ____________ Back Pain ____________
Pain During Cycles ____________ Pain Between Cycles ____________

7. Do you exercise regularly? ____________ If yes, what kind and how often? ____________

8. Do you smoke? ________ If yes, how many packs a day? ____________

9. Do you use alcohol? ________ If yes, how much do you use daily? ____________

10. List any medications you are currently taking and the reason for the medication. ____________
____
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11. List any reasons you have been hospitalized.______________________________

12. **Do you have any medical history of the following: check (√) all that applies.**

ق Diabetes ق High blood pressure ق Heart disease ق Previous heart attack
ق Heart palpitations ق Cancer ق Thyroid problems ق Skin disorders
ق Lung disorders ق Emphysema ق Asthma ق Stomach/colon disorder
ق Gallbladder disease ق Kidney/bladder disorder ق Prostate problems ق Bleeding tendencies
ق Latex allergy ق Medication allergy ق Blood clots ق Gyn/female disorder
ق Undiagnosed blood in the urine

13. Is there any chance you could be pregnant? ______________________________

14. If you are not pregnant, what is your method of birth control? ______________________________

15. List any medication allergies you have: ______________________________

16. Please list any other type(s) of allergies you have: ______________________________

17. Please list any surgery you have had: ______________________________

12. Please place a check (√) by any problems you have had with the following.

General Health

ق Malaise ق Weight loss, unexplained ق Unexplained fever ق Swollen glands
ق Severe headaches ق Thyroid problems ق Bleeding disorders

E.E.N.T.

ق Blurred vision ق Double vision ق Night blindness ق Frequent sore throat
ق Chronic earaches ق Swollen neck glands ق Enlarged thyroid ق Goiter
ق Chronic runny nose ق Frequent nosebleeds

Cardiovascular

ق Severe chest pain ق Leg pain w/walking ق Leg swelling ق Palpitations
ق Shortness of breath w/exertion

Respiratory

ق Wheezing ق Asthma attacks ق Shortness of breath ق Difficulty breathing

Please list any additional information you feel pertinent:______________________________

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information (Please Print):

Name ______________________________________ Date of Birth ___________________

SSN ____ Phone _________________________

Address ____

City _________________________________ State _______ Zip code ________________

RELEASE MY MEDICAL RECORDS TO:

____, MD________

Piedmont Radiology
Phone: 404-352-1409
Fax: 404-352-8176

I AUTHORIZE PIEDMONT RADIOLOGY TO RELEASE RECORDS TO:

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Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MY MEDICAL RECORDS

Patient ____Date ____________________