

Tennessee Valley Surgery Group, P.C.
PATIENT MEDICAL HISTORY

Name _____ Age _____ Date _____

Names of other physicians

Drug allergies

Reactions

Current medications / Dosage

Patient Medical History

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Blood clots | <input type="checkbox"/> TB | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Crohn's / Colitis | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Cancer | | <input type="checkbox"/> Other: | <input type="checkbox"/> Other |

Patient Surgical History

- | | | | |
|---|---|-----------------------------------|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Colon | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Ovaries 1 or 2 | <input type="checkbox"/> Lungs | <input type="checkbox"/> Breast () biopsy () mastectomy |
| <input type="checkbox"/> Stomach | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Prostate | <input type="checkbox"/> Heart () valve () bypass () stent |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Kidney | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Problems with anesthesia | | | <input type="checkbox"/> Other: |

Family History

- | Mother | Father | Brother/Sister | Grandmother | Grandfather |
|---|---|---|---|---|
| <input type="checkbox"/> Heart | <input type="checkbox"/> Heart | <input type="checkbox"/> Heart | <input type="checkbox"/> Heart | <input type="checkbox"/> Heart |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> TB | <input type="checkbox"/> TB | <input type="checkbox"/> TB | <input type="checkbox"/> TB | <input type="checkbox"/> TB |
| <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Blood pressure |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stroke |
| Living / deceased | Living / deceased | Living / deceased | Living / deceased | Living / deceased |
| Age at death: | Age at death: | Age at death: | Age at death: | Age at death: |

Social History

- Smoke If yes, packs per day _____ # of years _____
- Drinks alcohol If yes, how often ? _____
- Special diet IF yes, what kind? _____
- Occupation: _____ Marital status: Married Widowed Single Divorced

Females

- Date of last mammogram _____
- Date of last menstrual period _____
- Are you currently pregnant or have you missed a period? Yes No