Tennessee Valley Surgery Group,
PATIENT MEDICAL HISTORY

Name:_____Age:_____Date of Birth:_____Date:_____

Name of other physicians:_____

_____

Do you have any drug allergies? Yes or No
If yes, please list those drug allergies:_____

_____

Current Medications/Dosage: _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PATIENT MEDICAL HISTORY:

☐ Asthma	☐ Bleeding disorders	☐ TB	☐ Seizures
☐ Thyroid problems	☐ Blood clots	☐ Hepatitis	☐ Stroke
☐ Heart problems	☐ Diabetes	☐ Crohn's/Colitis	☐ Kidney disease
☐ Blood transfusions	☐ Lung disease	☐ Other_____	☐ Other_____
☐ Cancer_____	☐ HIV/AIDS	☐ Hypertension	☐ Chemo/Radiation Treatment

PATIENT SURGICAL HISTORY: (Please write the YEAR done, by each surgery you have had.)

☐ Appendectomy	☐ Hysterectomy	☐ Kidney	☐ Other_____
☐ Gallbladder	☐ Ovaries 1 or 2	☐ Hernia	☐ Other_____
☐ Stomach	☐ Tonsillectomy	☐ Breast Biopsy: Rt or Lt	☐ Colonoscopy?
☐ EGD	☐ Port a cath	Mastectomy: Rt or Lt	Year done:_____
☐ Colon	☐ Lungs	☐ Heart ( ) valves ( ) bypass	By whom:_____
☐ Thyroid	☐ Prostate	( ) stent	Where:_____

☐ Problems with anesthesia _____

FAMILY HISTORY: (Please specify TYPE of CANCER, by ones that apply, below)

Mother	Father	Brother/Sister	Grandmother	Grandfather
☐ Cancer_____	☐ Cancer_____	☐ Cancer_____	☐ Cancer_____	☐ Cancer_____
☐ Heart	☐ Heart	☐ Heart	☐ Heart	☐ Heart
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ TB	☐ TB	☐ TB	☐ TB	☐ TB
☐ Blood pressure	☐ Blood pressure	☐ Blood pressure	☐ Blood pressure	☐ Blood pressure
☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke

SOCIAL HISTORY:

☐ Smoke If yes, packs per day_____ # of years _____
☐ Drinks alcohol If yes, how often_____
☐ Special diet If yes, what kind_____
☐ Substance abuse If yes, when and type_____
Occupation:_____ Marital status: Married Widowed Single Divorced
Females:
Date of last mammogram_____ and where_____
Date of last menstrual period_____Are you currently pregnant or have missed a period? Yes No