TMH PHYSICIAN PARTNERS

TMH Physician Partners

PERSONAL HISTORY QUESTIONNAIRE

Patient Name:____ Birth date_______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Occupation: ____

Current Problem: ____

Please list your current medications and dosages (please include over-the-counter meds and herbal/nutritional supplements) – Use an additional sheet if necessary:

____
____
____

Do you have any drug allergies? ☐ No ☐ Yes If "YES" please list drug and type of reaction:

____

Please list:

Serious hospitalizations and dates:

____
____
____

Chronic illnesses:

____
____
____

Surgeries and dates:

____
____
____

Do you **currently** have any problems with these body systems?

	Yes	NO		Yes	NO		Yes	NO
EARS/HEARING			STOMACH/BOWELS			GENITALS		
EYES/VISION			KIDNEYS/URINE			BRAIN/NERVES		
MOUTH			BACK			SKIN		
NECK			JOINTS/ARMS/LEGS			PAIN		
CHEST/HEART			BREASTS			LUNGS		

	Yes	NO		Yes	NO
Do you smoke cigarettes or use tobacco?			Do you drink alcoholic beverages?		
Are you in a sexual relationship?			Have you ever had a blood transfusion?		
Do you use recreational drugs?			Have you experienced 10 lbs weight loss or weight gain in the past 3 months?		

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Patient Name: Birth Date:

	Yes	NO		Yes	NO
Do you have problems with mobility (need to use a wheelchair, cane or walker)?			Do you have a history of falls in the last year?		
Have you been feeling down, depressed or hopeless in the past 2 weeks?			Have you experienced little interest or pleasure in doing things in the past 2 weeks?		

Abuse is identified as a nation-wide problem and health concern. We are required to ask you the following:	Yes	NO
Are you in a relationship where you are being threatened or hurt?		

How many brothers and sisters do you have?___________ How many children do you have?________________

Do any of your direct **family** members (Mom = **M**, Dad = **D**, Sister = **S**, Brother = **B**, Child = **C**) have or have been treated for these conditions (Circle any that apply and check family member)?

	M	D	S	B	C		M	D	S	B	C
HEART DISEASE						HIGH BLOOD PRESSURE					
STROKE						ARTHRITIS					
HIGH CHOLESTEROL						DEPRESSION					
POOR CIRCULATION						EMPHYSEMA/ASTHMA					
BLOOD CLOTS						BLEEDING FREELY					
DIABETES						MENTAL ILLNESS					
CANCER						ULCERS					
ALCOHOLISM						DRUG ABUSE					

Name of Preferred Pharmacy: _______________________Location: _____________________________________

Name of Mail Order Pharmacy: ____

Do you see any other doctors? If so, whom:____

____

Date of last complete physical exam:____

Additional Information: ____

____

____