TMH PHYSICIAN PARTNERS

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Surgical Specialists Medical History

Patient Name:_____**Date**:_____

Date of Birth: _____/_____/_____**Age**:_____ **Height**:_____ **Weight**:_____lbs **Race**:_____

Reason for today's visit?_____

_____

Check any of the following problems that you currently have or have had:

☑		☑		☑		☑	
	High Blood Pressure		**Diabetes**		**Heart Disease**		**Arthritis**
	Blood Clots **DVT** **Pulmonary Embolisms**		**History of MRSA Infections**		**Stroke** **TIA**		

List any other current Medical Problems:

_____

_____

List family medical history that may pertain to you:

_____

List Operations or Procedures and when:

Year	Surgery	Year	Surgery

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Have you ever had a bleeding problem? (if yes, give details):

_____

Have you ever had a serious injury? (if yes, give details):

_____

Women only:
Are you currently receiving Hormone replacement therapy (HRT): _____
Age at onset of period: _____ Date of last period: _____ # of pregnancies ____ # of live children ____
Did you breastfeed? (if yes , how long): _____ Do you have breast Implants? _____

Do you currently smoke?____ Have you ever smoked? _____ Do you drink alcohol?_____ How often?_____

Do you wear: (circle one): Contact lenses: yes / no glasses: yes / no hearing aid: yes / no

	Yes	NO		Yes	NO
Do you use recreational drugs?			Have you experienced 10 lbs weight loss or weight gain in the past 3 months?		
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: Are you in a relationship where you are being threatened or hurt?					

Preferred Pharmacy Name: _____ Pharmacy Location _____

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Patient Name:_____ **Date of Birth** :_____/_____/_____

Drug Allergies & Reactions:_____

_____

Complete your medication list to be best of your ability:

Date	Please List Your Current Medications Name, Dosage & Route and Frequency	Condition Medication is Treating:

Reviewed

Date:___/____/_____ **Time:**_____ **Surgical Specialists Signature** _____

***Keep an updated medication list with you at all times in case of emergency situations. Update the information when medications are changed or discontinued. If you have been seen for a consult, give a copy of your medication list to your Primary Care Physician.