TMH PHYSICIAN PARTNERS

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SURGICAL SPECIALISTS
NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **Today's Date:** _____

Date of Birth: _____ **Age:** _____ **Height:** _____ **Weight:** _____

Reason for visit?_____

Please check any of the following health problems you have had or have now:

[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Stroke (or Mini-stroke)
[ ] Pain in the legs with walking
[ ] Aneurysm; location_____
[ ] Heart Attack
[ ] Angina/Chest Pain
[ ] Congestive Heart Failure
[ ] Pacemaker/AICD
[ ] Depression/Anxiety
[ ] Cataracts
[ ] Pneumonia
[ ] Emphysema (COPD)
[ ] Gastric Reflux
[ ] Ulcerative Colitis/Crohn's
[ ] Kidney Problems/Failure
[ ] Prostate Problems
[ ] Hepatitis
[ ] Bleeding/Clotting Problems
[ ] Abnormal Heart Rhythm
[ ] Thyroid Problems
[ ] Seizure Disorder
[ ] Stomach Ulcers
[ ] Sleep Disorder
[ ] Liver Problems
[ ] HIV/AIDS
[ ] Diabetes
[ ] Asthma
[ ] Anemia
Other: _____

List Operations or Procedures and when?

Year	Surgery	Year	Surgery

Family History: Please check the following health problems that have affected your family and identify their relationship to you, ie: mother, father, grandparent, sibling, child.

[ ] Stroke _____
[ ] Blood Clots _____
[ ] Bleeding Problems _____
[ ] High Blood Pressure _____
[ ] High Cholesterol _____
[ ] Thyroid problems _____
[ ] Heart Attack _____
[ ] Diabetes _____
[ ] Cancer _____
[ ] Lung disease _____
[ ] Asthma _____
[ ] Dialysis _____

Have you ever had a bleeding problem? [ ] No [ ] Yes; if yes please describe the problem: _____

_____

Have you ever had a serious injury? [ ] No [ ] Yes; if yes, please explain: _____

_____

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Patient Name: _____DOB: _____

Do you smoke? [ ]No [ ]Yes; if yes, packs /day: _____Year Quit: _____

Do you drink alcohol? [ ]No [ ]Yes; if Yes, drinks per day _____ Per week: _____

Do you use recreational drugs? [ ]No [ ]Yes; if yes, describe: _____

Women Only:
Are you currently receiving Hormone Replacement Therapy (HRT)? [ ] No [ ] Yes
Age at onset of period: _____Date of last period: _____ #of pregnancies _____ # of live births _____
Did you breastfeed? [ ] No [ ] Yes; if yes, how long? _____ Do you have breast implants? [ ] No [ ] Yes

Have you lost interest in doing things that use to give you pleasure?
[ ] Not at all, [ ] several days, [ ] more than half the days, [ ] nearly every day.

Have you been feeling down, depressed or hopeless in the past 2 weeks?
[ ] Not at all, [ ] several days, [ ] more than half the days, [ ] nearly every day.

Have you experienced 10 lbs weight loss or weight gain in the past 3 months? [ ] No [ ] Yes

Do you have problems with mobility (use a wheelchair, cane or walker)? [ ]No [ ] Yes; if yes, please describe the problem and/or the device used._____

Have you had a fall in the past year? [ ] No [ ] Yes

Do you feel unsteady? [ ] No [ ] Yes

Are you in a relationship where you are being threatened or hurt? [ ] No [ ] Yes

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

List Drug, Food, or Substance Allergies & Reactions:

_____
_____
_____

Preferred Pharmacy:_____ **Pharmacy Location:**_____

Complete your medication list to the best of your ability:

Date	Drug	Dose	Frequency	Indication

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.