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

Name_____ Age_____ Date of Birth_____ Date_____

Name of other physicians_____

Do you have any drug allergies? Please Circle: 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 transfusion	☐ Lung disease	☐ Other_____	☐ Other_____
☐ Cancer_____	☐ HIV/AIDS	☐ High blood pressure	

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?
☐ Thyroid	☐ Colon	Mastectomy-Rt or Lt	Year done?___
☐ Problems with	☐ Lungs	☐ Heart ( ) valves ( ) bypass	By whom?____
Anesthesia_____	☐ Prostate	( ) stent	Where?_____

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
Living/deceases	Living/deceases	Living/deceases	Living/deceases	Living/deceases
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_____and where_____
Date of last menstrual period_____
Are you currently pregnant or have you missed a period? Yes or No