Tampa General Medical Group

Surgery Health Survey

Name: _____

Social Security Number: _____ Date of Birth: _____

Please tell us which physician(s) we should contact regarding your visit:

REFERRING PHYSICIAN

Name: _____

Address: _____

_____

Phone: (____) _____-_____

Fax: (____) _____-_____

PRIMARY CARE PHSYICIAN

Name: _____

Address: _____

_____

Phone: (____) _____-_____

Fax: (____) _____-_____

PLEASE IDENTIFY ANY MEDICATION ALLERGIES AND REACTION TO THESE MEDICATIONS: _____

_____

Describe the chief complaint about your current health and the reason you are seeking a consultation: _____

_____

DIALYSIS UNIT

Name: _____ Phone: _____

Address: _____ Fax: _____

Dailysis start date: _____ Dialysis days: _____

Dialysis type: ☐ Hemo ☐ Peritoneal Cause of kidney disease: _____

Type of dialysis access: ☐ Graft ☐ Fistula ☐ Peritoneal catheter ☐ Hemodialysis catheter

Has your graft or fistula ever clotted? ☐ Yes ☐ No If yes, how many times? _____

Have you had peritonitis? ☐ Yes ☐ No If yes, date: _____

Have you had a renal biopsy? ☐ Yes ☐ No If yes, date: _____

What medications do you take?
Please include all current medications including diet aids, herbs, over the counter drugs (aspirin, arthritis pain relievers, Tylenol etc.), prescription drugs, oral contraceptives, recreational drugs, laxatives, tonics, vitamins and other minerals.

Name of medicine	Dose (mg)	How many times per day?

Have you received any of the following immunizations?

Name of vaccine			Date (year)
Smallpox vaccinations within last 7 years	☐ Yes	☐ No	_____
Tetanus shots	☐ Yes	☐ No	_____
Hepatitis A	☐ Yes	☐ No	_____
Hepatitis B	☐ Yes	☐ No	_____
Pneumovax	☐ Yes	☐ No	_____
Polio shots	☐ Yes	☐ No	_____

Describe any previous surgery:
(include childhood procedures such as tonsillectomy, broken bones etc.)

Operation/Injury	Month/Year
Fractures or cracked bones (specify opened or closed):	
Sprains:	
Lacerations:	
Dislocations:	
Concussion or head injury:	

Have you been diagnosed with any of the following medical illnesses? *See example:*

Condition	Date of onset	Comments/Outcome
EXAMPLE: High blood pressure	***1992***	***Started on pills, pressure better***
Pneumonia/bronchitis		
Hernia (type)		
Heart disease (specify type)		
Arthritis or rheumatism		
Polio or meningitis		
Gallbladder disease		
Anemia		
Jaundice/liver disease		
Epilepsy		
Alcohol/drug abuse		
Tuberculosis		
Diabetes (specify Type I or II)		
Cancer		
High blood pressure		
Ulcers (stomach or duodenal)		
Nervous breakdown		
Hay fever or asthma		
Frequent infections or boils		
HIV, AIDS		
Hepatitis (specify B or C)		
Kidney disease (stage)		

Please describe any family history of the following illnesses. Please include the relationship to you and any known outcome (cured, died, had an operation, etc.) If listing grandparents, aunts, uncles, etc., please specify maternal or paternal. *See example:*

Illness	Relation(s)	Outcome
EXAMPLE: Breast cancer	***Mother age 66, sister age 46***	***Both had operations to remove it***
Breast cancer		
Colon cancer		
Heart disease (specify type)		
High blood pressure		
Diabetes (specify I or II)		
Kidney disease		
Mental/emotional illness		
Stroke		
Seizures/epilepsy		
Alcohol abuse		
Drug abuse		
Liver disease		

High cholesterol		
Thyroid disease (hypo or hyper)		
Tuberculosis		
Bleeding tendency		
Epilepsy		
Nervous breakdown		
Suicide		
Goiter		

Social History:

Who lives at home with you now? _____

Who would be available to help you in the event of a major operation or severe medical illness?

_____

Education *(check)*: ☐ High school ☐ Tech school ☐ College ☐ Grad School

Employment *(check all that apply)*: ☐ Housewife ☐ Student ☐ Disabled ☐ Unemployed

If disabled or unemployed, describe previous employment: _____

_____

☐ Full-time ☐ Part-time Nature of employment:_____

Family *(check)*: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Children *(age and gender)*: _____

Smoking *(check or fill in all that apply)*:

Do you smoke? ☐ No ☐ Yes If yes, how much? _____

If no, have you ever smoked? ☐ No ☐ Yes When did you quit? _____

Alcohol *(check or fill in all that apply)*:

Do you drink alcohol? ☐ No ☐ Yes If yes, how much? _____

If no, did you ever drink alcohol? When did you quit? _____

Do you exercise regularly? ☐ No ☐ Yes

Review of Systems:

Please indicate (check or X) if you have experienced any of the following symptoms or signs:

General: ☐ Weight gain ☐ Weight loss ☐ Weakness ☐ Fatigue
☐ Fevers ☐ Other

Eyes: ☐ Pain ☐ Redness ☐ Tearing ☐ Dryness
☐ Double vision ☐ Glaucoma ☐ Cataracts ☐ Glasses
☐ Other

Ears:	☐ Itching	☐ Vertigo	☐ Infections	☐ Earaches
	☐ Discharge	☐ Hearing/Abnormal	☐ Tinnitus (ringing)	☐ Other
Nose:	☐ Frequent colds	☐ Stuffiness	☐ Bleeding	☐ Discharge
	☐ Frequent sinus	☐ Other		
Mouth:	☐ Gum bleeds	☐ Sore throats	☐ Tongue sores	☐ Hoarseness
	☐ Other			
Cardiac:	☐ Chest pain	☐ Murmur	☐ Dyspnea (shortness of breath)	
	☐ Shortness of breath when supine		☐ Rheumatic fever	☐ Edema
	☐ Abnormal heart test		☐ Palpitations	
	☐ Leg pain when walking		☐ Other heart problems	
Pulmonary:	☐ Cough	☐ Sputum	☐ Shortness of breath	
	☐ Bronchitis	☐ Emphysema	☐ Bloody cough	☐ TB
	☐ Wheezing	☐ Asthma	☐ Pneumonia	☐ Pleurisy
Gastro	☐ Constipation	☐ Nausea	☐ Black stool	☐ Indigestion
-Intestinal	☐ Swallowing problem		☐ Belching/Bloating	☐ Heartburn
	☐ Vomiting	☐ Diarrhea often	☐ Flatulence	
	☐ BM habit change	☐ Rectal bleeding	☐ Abdominal pain	☐ Hepatitis
	☐ Vomiting blood	☐ Other		
Skin	☐ Rashes	☐ Sore	☐ Dryness	☐ Hair loss
	☐ Lumps	☐ Itching	☐ Color change	
	☐ Nail change	☐ Other		
Breast	☐ Lumps	☐ Discharge	☐ Discomfort	☐ Self-exams
	☐ Other			
Neurological:	☐ Migraines	☐ Headaches	☐ Weakness	☐ Numbness
	☐ Tingling	☐ Tremors	☐ Fainting	
	☐ Seizures	☐ Vertigo	☐ Other	
Psychiatric:	☐ Anxiety	☐ Depressed	☐ Tension	☐ Bipolar
	☐ Nervousness	☐ Memory loss	☐ Libidoless	
	☐ Schizophrenia	☐ Other		

Genito-	☐ Urgency	☐ Painful urination	☐ Incontinence	☐ Sores
Urinary	☐ Painful menses	☐ Venereal disease	☐ Post menopause	☐ Hesitancy
	☐ Frequent urination	☐ Decreased stream	☐ Painful intercourse	☐ No menses
	☐ Birth control use	☐ Urination at night	☐ Blood in urine	
	☐ Kidney stones	☐ Other		
Blood/	☐ Anemia	☐ Bruising	☐ Thin blood	☐ Leukemia
Lymphatic	☐ Transfusions	☐ Enlarged nodes		
Bones/	☐ Joint pain	☐ Stiffness	☐ Arthritis	☐ Backache
Muscles	☐ Swelling	☐ Gout	☐ Other	
Endocrine	☐ Heat tolerance	☐ Cold intolerance	☐ Thyroid problem	☐ Diabetes
	☐ Thirst	☐ Frequent urination		☐ Sweating
	☐ Frequent hunger	☐ Other		

Please mention any other symptoms or illnesses not checked above:

_____

_____

_____

_____

_____

_____

_____

_____

_____