Patient Health Worksheet
TMB Medical Associates
Dr Toby Bond
706-548-9655

Please complete the following form to help us understand and provide better care to you as our patient. This will enable us to understand your medical history.

NAME: _____ DOB: _____ MALE/FEMALE

CURRENT MEDICATIONS : Please list all medications that you are currently taking (include prescribed, over the counter, herbals etc)If you need more room please use the last page

Drug Name	**Dosage**	**Taken how often**

MEDICAL HISTORY

Have you ever been diagnosed with any of the following:

Medical Condition	NO	YES	Medical Condition	NO	YES
Abnormal Heart Rhythm			**HEME/ONCOLOGY**		
Angina			Low Blood (anemia)		
Cardiomyopathy			Low Platelets		
Congestive Heart Failure			Leukemia		
Coronary Artery Disease			**MUSCULOSKELETAL**		
Heart Attack			Arthritis		
High Blood Pressure			Fibromyalgia		
High Cholesterol			Gout		
High Triglycerides			Rheumatoid Arthritis		
Cancer: What type?			**SKIN**		
PULMONARY			Cancer		
Asthma			**NEUROLOGICAL**		
Chronic Bronchitis			Seizures		
Emphysema			Strokes		
Sleep Apnea			**ENDOCRINE**		
Pneumonia			Diabetes		
GENITO-URINARY			High Thyroid		
Enlarged Prostate(BPH)			Low Thyroid		
Kidney Stones			**PSYCH**		
Kidney Failure			Depression		
Urinary Tract Infection			General Anxiety		
GASTRO			Panic Attacks		
GERD (heartburn)					
Ulcers					
Diarrhea					
Blood in stool					
GI Bleed					

ALLERGIES

Please list any allergies that you may have to drugs, foods, or other external items

_____ _____ _____

_____ _____ _____

SURGICAL HISTORY

Please list any surgeries that you have had and the date they were performed

NAME OF SURGERY	DATE OF SURGERY

FAMILY HISTORY

Please list any medical conditions found among the following members of your family. Please circle if they are currently living or if they are deceased. On the Grandparents, please circle if they are from your Mother's or Father's side of the family.

Mother: _(alive/deceased)_____

_____

_____

_____

Father: (alive/deceased) _____

_____

_____

_____

Grandfather : (alive/deceased)

_____ **mothers side fathers side**

_____ **mothers side fathers side**

_____ **mothers side fathers side**

Grandmother (alive/deceased)

_____ **mothers side fathers side**

_____ **mothers side fathers side**

_____ **mothers side fathers side**

SOCIAL HISTORY:

What is your occupation? _____

List any potential work related hazards: _____

Chemicals exposed to regularly: _____

Do you, or have you ever used any form of tobacco ? YES ____ NO ____

If so, do you still use? YES _____ NO____

Do you, or have you ever used alcohol? YES ____ NO ____

If so, how much? _____ How often? _____ Type? _____

Do you, or have you ever used drugs? YES ___ NO ___ Type? _____

REVIEW OF SYSTEMS

Please indicate if you currently have any of the following:

O Blood transfusions	O Nausea/Vomiting	O Bladder Infections	O Easy Bruising
O Changes in vision	O Muscle Weakness	O Constant Runny Nose	O Bloody or black stool
O Chest Pain	O Leg pain when walking	O Varicose Veins	O Broken Bones
O Chicken pox	O Abdominal Pain	O Skin disorders	O Voice Changes
O Dentures	O Difficulty Concentrating	O Recent Stressful Event	O Constipation
O Dizziness	O Nervousness	O Sexual Problems	O Diarrhea
O Ear Infections	O Sleeping Difficulty	O Breast Tenderness	O Changes in bowels
O Eye Problems	O Moodiness	O Reaction to Bee Stings	O Hemorrhoids
O Fatigue	O Memory Loss	O Bone Pain	O Coughing up Blood
O Hearing problems	O Hot or Cold Intolerance	O Enlarged Thyroid Gland	O Heartburn/Acid Reflux
O Painful Intercourse	O Loss of Bladder Control	O Poor Circulation	O Swallowing Difficulty
O Recurrent nose bleeds	O Hot Flashes	O Hives/Itching	O Shortness of Breath
O Rheumatic fever	O Painful Urination	O Excessive Sneezing	O Swollen Ankles
O Sinus Changes	O Heart Murmur	O Joint Pain	O Fainting spells
O Sweats	O Excessive Thirst	O Recurrent Bleeding	O Gallbladder/liver problems
O Watery Eyes	O Headaches/Migraines	O Muscle Pain	O Wheezing
O Weight loss			

TESTS AND PROCEUDRES: Please indicate approximately when test/procedure was performed and the result

TEST	DATE	RESULT	TEST	DATE	RESULT
O Colonoscopy		Normal / Abnormal	O Dental Exam		Normal / Abnormal
O Stool tests for blood		Normal / Abnormal	O Hearing Test		Normal / Abnormal
O Rectal Exam		Normal / Abnormal	O Eye Exam		Normal / Abnormal
O Prostate Test (PSA)		Normal / Abnormal	O Chest Xray		Normal / Abnormal
O Exercise Stress Test		Normal / Abnormal	O EKG		Normal / Abnormal
O Papsmear/Pelvic Exam		Normal / Abnormal	O TB test		Normal / Abnormal
O Mammogram		Normal / Abnormal	O Blood Work		Normal / Abnormal
O Cholesterol		Normal / Abnormal	O Other		Normal / Abnormal