Tampa General Medical Group

Hepatology 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 PHYSICIAN:

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: _____

_____

_____

_____

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?

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

Operation/Injury/Hospitalizations	**Month/Year**

Have you received any of the following procedures?

Procedure	**Month/Year**	**Where**
Colonoscopy		
EGD		
Liver biopsy		

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***
Cirrhosis of the liver		
Hepatitis (A,B,C)		
Jaundice		
HIV/AIDS		
GI bleed		
Ulcers (stomach or duodenal)		
Pancreatitis		
Colitis		
Reflux disease (GERD)		
Tuberculosis		
Anemia		
Mental/emotional illness		
Thyroid disease		
Diabetes (specify type)		
High blood pressure		
Cancer		
Seizures		
Coma		
Heart disease		
Asthma		
Alcohol/drug abuse		

Have you received any of the following immunizations?

Name of Vaccine			**Date (year)**
Influenza (flu)	☐ Yes	☐ No	_____
Hepatitis A	☐ Yes	☐ No	_____
Hepatitis B	☐ Yes	☐ No	_____
Pneumovax	☐ Yes	☐ No	_____
Chicken Pox	☐ Yes	☐ No	_____
Tetanus	☐ Yes	☐ No	_____

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		
High blood pressure		
Diabetes		
Kidney disease		
Mental/emotional illness		
Stroke		
Seizures/epilepsy		
Alcohol abuse		
Drug abuse		
Liver disease		
High cholesterol		
Thyroid disease (specify hyper or hypo)		

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

Marital Status*:* ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Children *(age and gender):* _____

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

If disabled or unemployed, describe previous employment: _____

_____

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

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

☐ Never smoked ☐ Smoke now ☐ Quit smoking (date)_____

☐ ½ Pack/day ☐ 1 Pack/day ☐ 2 Packs/day I have smoked _____ years.

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

☐ Never drank Started drinking alcohol at what age? _____

☐ Quit drinking (date) _____ What did you enjoying about drinking? _____

☐ Did you drink every day? How much/how often? _____

☐ Do you drink alcohol now? What do you enjoy about drinking? _____

☐ Do you drink every day? How much/how often? _____

I have the following risk factors for Hepatitis ***(check all that apply):***

Blood transfusion, # of units: _____ Year(s) you were transfused:_____

☐ Tattoos Piercing ☐ Acupuncture ☐ Homosexual Bisexual

☐ Exposure to hazardous chemicals ☐ Used IV street drug Date of last use: _____

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)	
	☐ Rheumatic fever	☐ Shortness of breath when supine		
	☐ Abnormal heart test		☐ Palpitations	☐ Edema
	☐ Leg pain when walking		☐ Other heart problems	
Pulmonary:	☐ Cough	☐ Sputum	☐ Shortness of breath	
	☐ Bronchitis	☐ Emphysema	☐ Bloody cough	☐ TB
	☐ Wheezing	☐ Asthma	☐ Pneumonia	☐ Pleurisy
	☐ Other lung disease			
Gastro	☐ Constipation	☐ Nausea	☐ Black stool	☐ Indigestion
-Intestinal	☐ Vomiting	☐ Belching/Bloating	☐ Heartburn	☐ Flatulence
	☐ Diarrhea often	☐ BM habit change	☐ Rectal bleeding	☐ Hepatitis
	☐ Abdominal pain	☐ Vomiting blood	☐ Swallowing problem	☐ 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:

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