General Surgical Associates

NEW PATIENT QUESTIONNAIRE

Are you having any of the following symptoms? (Circle Yes or No)

Unplanned weight loss (>10 lbs/month)	Yes	No
Fever (>101)	Yes	No
Night sweats	Yes	No
Chest pains	Yes	No
Heart palpitations	Yes	No
Swollen ankles/feet	Yes	No
Shortness of breath	Yes	No
Chronic coughing	Yes	No
Wheezing or asthma attacks	Yes	No
Nausea with vomiting	Yes	No
Trouble swallowing	Yes	No
Abdominal pain or cramping	Yes	No
Recurrent diarrhea	Yes	No
Blood in stool or urine	Yes	No
Change in stool size/color	Yes	No
Pain while urinating	Yes	No
Intense headaches	Yes	No
Blackouts or seizures	Yes	No

9/03

Name:_____ DOB:_____

Signed:_____ Date:_____