

GENERAL SURGICAL ASSOCIATES

NAME	SEX M F	DATE
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AGE	DATE OF BIRTH	OCCUPATION
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WHAT IS THE MAIN PROBLEM FOR WHICH YOU HAVE COME TODAY, AND HOW LONG HAS IT BEEN GOING ON?

CIRCLE ANY MEDICAL CONDITIONS YOU HAVE HAD: Diabetes High Blood Pressure Heart Trouble / Heart Attacks Stroke
 Easy Bleeding / Bruising Asthma / Pneumonia / Bronchitis Kidney Disease Hepatitis Cancer (lung, breast, colon, ovary)

OTHER ILLNESSES FOR WHICH YOU ARE ON MEDICATION OR HAVE SEEN A PHYSICIAN:

PAST OPERATIONS YOU HAVE HAD: (Include surgery, date, and name of surgeon) Gallbladder Hernia Colon Heart bypass / valve

MEDICATIONS (Include herbal, nutritional or dietary supplements). Include Name and Dose Taken:

ANY ALLERGIC REACTIONS TO MEDICINES OR OTHER SUBSTANCES? (List Medicine / Describe Reaction)	HAVE YOU TAKEN CORTISONE-TYPE DRUGS? No Yes
_____ _____	ARE YOU TAKING ORAL CONTRACEPTIVES? No Yes

DO YOU USE TOBACCO NOW?	IN THE PAST?	TYPE AND DAILY AMOUNT	HOW LONG?
No Yes	No Yes		

DO YOU USE ALCOHOLIC BEVERAGES?	TYPE	WEEKLY AMOUNT	HOW LONG?
No Yes			

DATE OF LAST MENSTRUAL PERIOD	PERIODS ARE	NUMBER OF PREGNANCIES	NUMBER OF MISCARRIAGES
	Regular Irregular		

ANY EXPOSURE TO HIV / AIDS?	ANY IV DRUG ABUSE?	HAVE YOU EVER HAD A BLOOD TRANSFUSION?
No Yes	No Yes	No Yes DATE:

USUAL WEIGHT	HOW LONG HAVE YOU BEEN AT THIS WEIGHT?
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CIRCLE ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES Diabetes Cancer Easy Bleeding / Bruising
 Kidney Disease Tuberculosis Heart Disease Stroke High Blood Pressure Nervous Illness Allergy Other

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE -	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
DECEASED -	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
BROTHER -	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
SISTERS -	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
CHILDREN -	NO. ALIVE	AGES & HEALTH		NO. DECEASED	AGES & CAUSE OF DEATH	

FORM COMPLETED BY-	SIGNATURE
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