GSA GENERAL SURGICAL ASSOCIATES

NAME	SEX M F	DATE
AGE / DATE OF BIRTH / OCCUPATION		

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 / Obesity / Sleep Apnea Kidney Disease Hepatitis Cancer (lung, breast, colon, ovary)

OTHER ILLNESSES THAT ARE NOT LISTED ABOVE and/or ADDITIONAL DETAILS ABOUT THE ABOVE:

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:

PREFERRED PHARMACY: PHARMACY PHONE NUMBER:

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? NO YES	IN THE PAST NO YES	TYPE AND DAILY AMOUNT	HOW LONG?
DO YOU USE ALCOHOLIC BEVERAGES? NO YES	TYPE	WEEKLY AMOUNT	HOW LONG?

DATE OF LAST MENSTRUAL PERIOD	PERIODS ARE REGULAR IRREGULAR	NUMBER OF PREGNANCIES	NUMBER OF MISCARRIAGES

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

USUAL WEIGHT	HOW LONG HAVE YOU BEEN AT THIS WEIGHT?

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	☐		☐		☐	
DECEASED	☐		☐		☐	

	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH
BROTHERS				
SISTERS				
CHILDREN	NO. ALIVE	AGES & HEALTH	NO. DECEASED	AGES & CAUSE OF DEATH

FORM COMPLETED BY: SIGNATURE