GSA
GENERAL SURGERY
ASSOCIATES

PATIENT NAME: _____ **TODAY'S DATE**:____/_____/_____

MEDICAL HISTORY:

Reason for today's visit: _____

Medical Conditions/Diagnoses: _____

_____

_____

Previous Surgical Procedures/Operations & Dates: _____

_____

_____

Have you had a colonoscopy? No / Yes. If yes, when was this performed? _____

Are you currently pregnant? No / Yes, # of weeks: _____

Current Medication/Dosages: _____

_____

Are you currently taking any blood thinners-prescription or over the counter? No / Yes, _____
Aspirin/Arixtra/Aleve/Ibuprofen/Warfarin/Coumadin/Plavix/Pradaxa/Mobic/Effient/Fish Oil

Allergies/Reaction: _____

Latex Sensitivity: No / Yes, reaction: _____

Significant Family Medical History: _____

_____

Has there been any patient or family history of: Anesthesia Problems? No / Yes, reaction: _____
Bleeding Problems? No / Yes, reaction: _____

SOCIAL HISTORY:

Tobacco Use No / Yes, Amount: _____
Alcohol Use No / Yes, Amount: _____
Illicit Drug Use No / Yes, Amount: _____

How tall are you? _____ How much do you weigh? _____