

**GAINESVILLE SURGICAL ASSOCIATES, L.L.C.**  
Medical Information Sheet

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please list the name of the physician who referred you here: \_\_\_\_\_

Who is your family doctor? \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

Describe your present illness and/or symptoms: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

List any treatment you have had: \_\_\_\_\_

\_\_\_\_\_

List any tests (X-Rays or Lab Test) you have had for this problem: \_\_\_\_\_

\_\_\_\_\_

When/Where the test were performed? \_\_\_\_\_ Ordered by: \_\_\_\_\_

List all medications **including herbs and/or vitamins** that you currently take and the dosage:

Name	Dosage	Times take daily

Are you allergic to any medication, latex or adhesives? If so please list \_\_\_\_\_

What reaction did you have? \_\_\_\_\_

List all surgeries that you have had and the dates: \_\_\_\_\_

\_\_\_\_\_

List any hospitalizations within the last 3 years, reasons, dates, hospital name and physician:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What past or present medical illnesses or injuries have you had? \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever had problems with anesthesia? \_\_\_\_\_

Are you currently taking aspirin or an aspirin based product? \_\_\_\_\_ If so, what? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Have you ever smoked? \_\_\_\_\_ How much? \_\_\_\_\_

If you have ever smoked, when did you stop? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How often? \_\_\_\_\_ How much? \_\_\_\_\_

Are you married? \_\_\_\_\_ Do you have children? \_\_\_\_\_ What are their ages? \_\_\_\_\_

Could you be pregnant now? \_\_\_\_\_

Do any of these medical illnesses run in your family? If so, list their relation to you

Cancer	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Family Member	_____
Heart Problems	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Family Member	_____
Diabetes	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Family Member	_____
Asthma	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Family Member	_____
Stroke	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Family Member	_____
High Blood Pressure	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Family Member	_____

**Please circle all that you have experienced or are experiencing now.**

**General**

Gained or lost weight  
Fever or chills

**Eyes**

Blurred vision  
Double vision  
Loss of vision

**Ears, Nose, Throat**

Hearing loss  
Discharge from nose  
Post-nasal drip  
Bleeding gums  
Sore throat

**Cardiovascular**

Chest pain  
Irregular heart beat  
Heart attack  
Murmur  
Can't sleep flat  
Leg swelling  
High Blood Pressure

**Respiratory**

Shortness of breath  
Wheezing  
Cough

**Gastrointestinal**

Nausea or vomiting  
Diarrhea or constipation  
Blood in stool or Black stools  
Reflux or Indigestion  
Jaundice (yellow skin)

**Breasts**

Breast problems

**Reproductive (Female)**

When was your last period?  
Vaginal discharge or bleeding

**Urinary**

Trouble urinating  
Get up at night to urinate  
Pain or burning with urination

**Reproductive (Male)**

Blood or discharge from penis  
Lump on testicle

**Musculoskeletal**

Back or joint pain  
Stiffness or swelling of joints

**Skin**

Rash or itching  
Worrisome moles or spots

**Neurologic**

Ever had a seizure  
Weakness or paralysis  
Numbness or tingling

**Psychiatric**

Feel depressed or anxious  
Had any mental disturbances

**Endocrine**

Diabetes  
Thyroid disorder

**Hematology**

Abnormal bleeding or bruising  
Anemia (low blood count)  
Blood clots

**Allergic/Immunologic**

Hives or hay fever  
Get infections easily

Dr.'s initials \_\_\_\_\_ Date \_\_\_\_\_ Updated: \_\_\_\_\_