GRANTS PASS SURGICAL ASSOCIATES P.C.

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GENERAL SURGERY ASSESSMENT

PATIENT INFORMATION

Today's Date _____

Name (Last) _____ First _____ Middle _____

What do you prefer to be called? _____ Birth Date _____ Age _____

What is your pharmacy of choice? _____

Name of your Family Physician or Referring Provider _____

Language _____ Race _____ Nationality _____ Country of Origin _____

Allergies _____

MEDICATIONS

List all medications you take regularly (including prescription drugs, vitamins, herbals, and over-the-counter):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

MEDICAL HISTORY (check all that apply)

- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation
- ☐ Hypertension
- ☐ Heart Valve Disease
- ☐ COPD
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's Disease/ Ulcerative Colitis
- ☐ GERD/Heartburn
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease
- ☐ Colon Polyps
- ☐ Diverticulosis/Diverticulitis
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Renal Disease or Failure
- ☐ Kidney or Urinary Infection
- ☐ Thyroid Disease
- ☐ Depression or Anxiety
- ☐ Seizures
- ☐ Glaucoma
- ☐ Aneurysm
- ☐ Stroke or TIA (Transient Ischemic Attack)
- ☐ Carotid Artery Disease
- ☐ Varicose Veins
- ☐ Leg pain with walking
- ☐ DVT/Blood clots
- ☐ Pulmonary Embolism
- ☐ Bleeding disorder
- ☐ Anemia
- ☐ Rheumatic disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Other _____
- ☐ _____

Name _____ DOB _____

SURGICAL HISTORY (please include approximate date and surgeon/facility)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

COLONOSCOPY

Have you had a colonoscopy? ☐ No ☐ Yes, when? _____

Results? _____

SOCIAL

How much alcohol do you drink? _____

Have you ever used tobacco? ☐ Yes ☐ No If you already quit, when? _____

Marijuana? ☐ Yes ☐ No

Other drugs? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

Please list any diseases that run in your family (for example, heart disease, stroke, bleeding disorders)

_____

_____

If there is a family history of cancer, please complete the table on the next page.

FOR WOMEN

Date of last menstrual period _____

Date of last mammogram _____ History of abnormal mammograms? ☐ Yes ☐ No

Date of last Pap smear _____ History of abnormal Pap exams? ☐ Yes ☐ No

Number of pregnancies _____ Number of live births _____

Name _____ DOB _____

FAMILY CANCER HISTORY

Please list your family member's relation to you and their age at cancer diagnosis.*

	Mother's Side	Father's Side
Uterine Cancer		
Colon/Rectal Cancer		
Stomach Cancer		
Small Bowel Cancer		
Brain Cancer		
Kidney or Urinary Tract Cancer		
Colon Polyps		
Breast Cancer		
Ovarian Cancer		
Pancreatic Cancer		

Ashkenazi Jewish Decent? ☐ Yes ☐ No

Have you or your family members ever had genetic testing? ☐ No ☐ Yes, results? _____

Is there any other *cancer* in a family member that is not listed above? Please list their relation and age at diagnosis here: _____

* *First Degree Relatives = Mother/Father/Sister/Brother/Children*

Name _____ DOB _____

Please check if you are CURRENTLY having trouble with any of the following (check all that apply):

GENERAL
- ☐ Fever ☐ Chills ☐ Sweats
- ☐ Headache/Migraine
- ☐ Decreased Appetite
- ☐ Fatigue
- ☐ Feeling Poorly (Malaise)
- ☐ Weight Loss

EYES
- ☐ Blurring
- ☐ Double vision (Diplopia)
- ☐ Irritation
- ☐ Discharge
- ☐ Vision loss
- ☐ Eye Pain
- ☐ Light Sensitivity

EARS/NOSE/THROAT
- ☐ Earache
- ☐ Ear Discharge
- ☐ Ringing of the Ears (Tinnitus)
- ☐ Decreased Hearing
- ☐ Nasal Congestion
- ☐ Nosebleeds
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Trouble Swallowing

HEART/VASCULAR
- ☐ Chest Pains
- ☐ Palpitations
- ☐ Fainting (Syncope)
- ☐ Painful breathing with exercise
- ☐ Lightheaded when standing up
- ☐ Peripheral Vascular Disease
- ☐ Swelling of Arms/Legs

OTHER
- ☐ _____

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea (6+ loose stools daily)
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Abdominal Pain
- ☐ Black stools (Melena)
- ☐ Blood in stool
- ☐ Yellow Skin (Jaundice)

GENITOURINARY
- ☐ Vaginal Discharge
- ☐ Incontinence
- ☐ Painful Urination (Dysuria)
- ☐ Blood in Urine (Hematuria)
- ☐ Urinary Frequency
- ☐ No periods (Amenorrhea)
- ☐ Abnormal Menstrual Bleeding
- ☐ Pelvic Pain

MUSCULOSKELETAL
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Stiffness
- ☐ Arthritis

NEUROLOGIC
- ☐ Transient Paralysis
- ☐ Weakness
- ☐ Paresthesias (numbness)
- ☐ Seizures
- ☐ Passing out (Syncope)
- ☐ Tremors
- ☐ Dizziness (Vertigo)

RESPIRATORY
- ☐ Cough
- ☐ Painful Breathing (Dyspnea)
- ☐ Excessive Sputum
- ☐ Spitting up Blood
- ☐ Wheezing

SKIN
- ☐ Rash
- ☐ Itching
- ☐ Dryness
- ☐ Suspicious Lesions

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Memory Loss
- ☐ Mental Disturbance
- ☐ Suicidal Ideation
- ☐ Hallucinations
- ☐ Paranoid

ENDOCRINE
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Excessive Urine
- ☐ Weight Loss

HEME/LYMPHATIC
- ☐ Abnormal Bruising
- ☐ Bleeding
- ☐ Enlarged Lymph Nodes

ALLERGIC/IMMUNOLOGIC
- ☐ Itching (Urticaria)
- ☐ Hay Fever
- ☐ Persistent Infections
- ☐ HIV Exposure