



GENERAL & VASCULAR
SURGEONS, P.C.

Today's Date: _____

Patient Name: _____

Date of Birth: _____

Height: _____

Weight: _____

Primary Care Physician: _____

Are you allergic to any medicines? No Yes

If Yes, please list: _____

Do you smoke? No Yes If yes, how much? _____

Do you drink? No Yes If yes, how much? _____

Current or Previous Steroid use? No Yes If yes, name & dose? _____

Current or Previous Blood Thinner use? No Yes If yes, name? _____ When? _____

Do you have a history of:

Yes No Tuberculosis

Yes No Asthma

Yes No Heart Disease

Yes No Gout

Yes No Lung Disease

Yes No Hardening of the Arteries

Yes No Breast Cancer

Yes No Arthritis

Yes No Diabetes

Yes No Colon Polyps

Yes No Kidney Disease

Yes No High Blood Pressure

Yes No Colon Cancer

Yes No Hepatitis

Yes No Stroke

Yes No Colitis

Yes No Blood Transfusions

Yes No Paralysis

Yes No Stomach Problems/Ulcers

Yes No Bleeding Tendency

Yes No Varicose Veins

Yes No Seizures

Yes No Chemical Dependency

Yes No Previous Anesthesia Prob.

List all Past Operations & Serious Illnesses

Operation of Illness

Month & Year

Operation of Illness	Month & Year

List all Medications that You are Currently Taking (continue on other side if necessary)

Medicine

Dose

How Often

For what illness or condition?

Medicine	Dose	How Often	For what illness or condition?