GSA
GENERAL SURGERY
ASSOCIATES

Date of Appointment: _____

First Name: _____ Middle Initial: _____ Last Name: _____

SSN: _____ Birthdate: _____ Age: _____ Marital Status _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ E-Mail

Employer: _____ Occupation: _____ Work #: _____

Spouse Name: _____ Spouse Phone: _____ Spouse Employer: _____

Additional Emergency Contact: _____ Phone: _____ Relation: _____

Primary Language: ☐ English ☐ Spanish ☐ French ☐ Arabic ☐ Other _____

Race: ☐ American Indian ☐ Asian ☐ African American ☐ White ☐ Other ☐ Decline to Answer

Are you Hispanic or Latino? ☐ Y ☐ N ☐ Decline to Answer

Primary Insurance: _____ Secondary Insurance _____

Policy Holder Name and Date of Birth: _____

Primary Doctor: _____ Referring Doctor: _____

Preferred Pharmacy: _____

Patient's Relationship to Responsible Party: **If "Self", skip to signature section** ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other _____

Name: _____ SSN: _____ DOB: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Address: _____ City: _____ State: _____ Zip: _____

Driver's Lic #: _____ Employer: _____ Work #: _____

Please check the box next to each section below indicating you have read, understand, and agree to each section and sign below:

☐ The above-named patient is either a **minor under 19** or an incapacitated adult requiring diagnosis and treatment. As legal guardian, I consent to such diagnostic procedures and treatments as necessary in the judgement of the doctors at GSA and/or their assistants.

☐ **MEDICATION HISTORY AUTHORITY:** General Surgery Associates has implemented an Electronic Health Records (EHR) system through Athenahealth that will automatically import the last 13 months of your medication history. This information is downloaded from the Pharmacy Benefits Manager utilized by your health insurance company. By signing below, I hereby authorize General Surgery Associates to download my Medication History.

☐ **ACKNOWLEDGEMENT OF RECEIPT / NOTICE OF PRIVACY PRACTICES:** I understand that upon request, I may obtain a copy of the Notice of Privacy Practices of General Surgery Associates, LLC.

☐ **ASSIGNMENT OF BENEFITS:** I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for the recommended services performed that are not covered under the terms of my health plan. I authorize the physician to release any medical information required to process this claim. I authorize my provider's office to contact me to remind me of my appointments.

Responsible Party Signature: _____ **Date:** _____

If you would like to give GSA permission to release your medical information to **someone other than your primary care or referring provider** (such as spouse, family member, friend, etc.) please provide their information below:

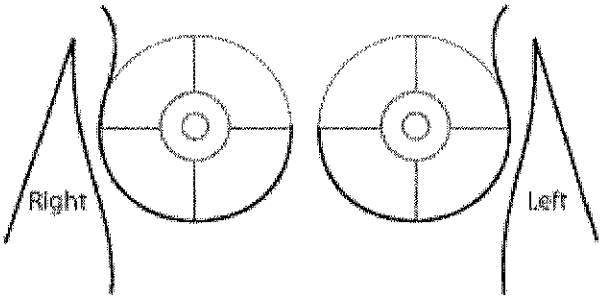
Name	Phone Number	Relation

NAME: _____ **DATE:** _____

Have you had a recent mammogram? Yes No
Date:_____ Location completed:_____

Have you had a recent breast ultrasound? Yes No
Date:_____ Location completed:_____

Can you feel a breast mass? Yes No If yes, please mark on diagram



At what age did you start your menstrual cycle? _____ When was your last cycle? _____

Have you had a hysterectomy? Yes No If yes, were your ovaries removed? Yes No

Number of biological children: _____ Did you breastfeed? Yes No

Do you have breast pain? Yes No
Do you take medicine for breast pain? Yes No If yes, name: _____
Does the pain come and go or is it constant? _____

Do you have any breast skin changes such as dimpling or redness? _____

Do you have nipple discharge? Yes No
If so: Right/ Left/ Both Breasts
Color of discharge: clear, yellow/green, bloody, rusty, milky
Does it come out on its own or only when squeezing the breast?

Have you ever had a breast biopsy or operation? Yes No
If yes: Right Left

If yes, what type of procedure:

- ❑ surgical excision of breast lump
- ❑ needle core biopsy
- ❑ lumpectomy for cancer
- ❑ lymph node sampling for cancer
- ❑ mastectomy
- ❑ implants
- ❑ reduction/lift
- ❑ fine needle biopsy

Date:_____ Location performed:_____

Have you ever had a cyst in your breast? Yes No Right Left

FAMILY HISTORY

Do you have a family history of breast cancer on your maternal/paternal side? Yes No

If yes, please circle the family members with history of cancer:

- ❑ First degree relatives: Mother Father Sister Brother Children
- ❑ Second degree relatives: Aunt Uncle Niece Nephew Grandparents Grandchildren Half-siblings
- ❑ Third degree relatives: Cousin Great grandfather Great grandmother Great aunt Great uncle

Did any of the above people on either maternal and/or paternal side have any of the following cancer types:

Ovarian? Yes No Whom and age_____

Colorectal? Yes No Whom and age_____

Endometrial/Uterine? Yes No Whom and age_____

Prostate? Yes No Whom and age_____

Pancreatic? Yes No Whom and age_____

Stomach/Gastric? Yes No Whom and age_____

Other: Kidney, Brain, Biliary Tract, Small Bowel, urinary tract cancers? Yes No

NAME: _____ **DATE:** _____

Has anyone in your family been tested for a genetic gene mutation such as BRCA 1 & 2 or

MyRisk Panel? Yes No If yes, then whom_____

Have you ever had breast cancer? Yes No Right /Left Age at diagnosis_____
Did you need radiation? Yes No Name of radiation oncologist:_____
Did you need chemotherapy? Yes No Name of oncologist:_____

Have you in the past or are you currently taking:
Tamoxifen, Arimidex, Femera, or other anti-cancer medication?_____

Have you ever or are you currently taking: Check the following:

- ❑ Estrogen Name: _____ Length of time on_____
- ❑ Progesterone Name: _____ Length of time on_____
- ❑ Birth control pills Name:_____Length of time on_____
- ❑ Infertility medications Name: _____ Length of time on _____

MEDICAL HISTORY:

Medical Conditions/ Diagnosis: _____

Previous Surgical Procedures: _____

Current Medications:

_____

_____

Allergies & Reaction: _____

SOCIAL HISTORY:

Tobacco Use: No Yes, amount: _____

Alcohol Use: No Yes, amount: _____

Illicit Drug Use: No Yes, amount: _____

Height:_____ Weight:_____ Blood Pressure:_____

GENERAL SURGERY ASSOCIATES

REVIEW OF SYSTEMS

Patient Name: _____ Date: _____

PLEASE CIRCLE THE APPROPRIATE ANSWER TO THE FOLLOWING CONDITIONS THAT YOU MIGHT BE EXPERIENCING:

Y / N Fevers

Y / N Night Sweats

Y / N Weight Loss/Weight Gain

Y / N Vision Changes

Y / N Hearing Loss

Y / N Nose Bleeds

Y / N Sinus Problems

Y / N Sore Throat

Y / N Chest Pain

Y / N Heart Palpitations

Y / N Heart Murmur

Y / N Pacemaker/Defibrillator

Y / N Shortness of Breath

Y / N Cough

Y / N Sleep Apnea

Y / N Abdominal Pain

Y / N Nausea/Vomiting

Y / N Diarrhea

Y / N Constipation

Y / N Gastroesophageal Reflux Disease (GERD)

Y / N Incontinence

Y / N Blood in Urine

Y / N Muscle Aches

Y / N Muscle Weakness

Y / N Rheumatoid Arthritis

Y / N Gout

Y / N Swelling of the Hands or Feet

Y / N Abnormal Skin Lesions

Y / N Psoriasis

Y / N Jaundice

Y / N Seizures

Y / N Headaches/Migraines

Y / N Dizziness

Y / N Anxiety

Y / N Depression

Y / N Swollen Glands

Y / N Bruising