

Dr Geiss and Dr Powers Center for Surgical Specialties Laparoscopy Center

PATIENT NAME: _____ DATE: _____

Email address: _____

REASON FOR VISIT/CHIEF COMPLAINT: _____

Please check or circle all of the following that apply to you, as diagnosed/treated by your Dr:

- | | |
|----------------------------------|---------------------|
| ____ High Blood Pressure | ____ Asthma |
| ____ High Cholesterol | ____ Sleep Apnea |
| ____ Diabetes- uses Insulin | ____ GERD/Heartburn |
| ____ Diabetes- not using Insulin | |
| ____ Anxiety/depression | ____ Arthritis |
- Blood disorder (hepatitis, past transfusion, clotting/bleeding problems) _____
- Heart Disease (blocked arteries, enlarged heart, past MI/heart attack, TIA/Stroke) _____
- Kidney Disease (damage to kidney function from Diabetes, high creatinine) _____
- GI Disorder (IBS/Irritable Bowel Syndrome, Crohn's disease) _____

Please list all previous operations, including the hospital where they were performed:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

Hospitalization for illness or other reason, please give dates and explain:

Have you had any problems with anesthesia or during surgery? Please explain:

Please List **ALL** your medications, dose and frequency- including **Aspirin** and over the counter medicine if taken regularly (attach sheet, if needed):

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

Please list allergies to Medicine/food and your reaction: _____

Are you allergic to LATEX? _____

Tobacco use: how much /how long? _____ When did you quit? _____

How many Alcoholic drinks do you consume per week, on average? _____

Please give a brief family history of diseases and/or deaths of your blood relatives:

Mother: _____

Father: _____

Siblings: _____

Children: _____