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S U R G I C A L   A S S O C I A T E S   O F   G A D S D E N

Patient History & Yearly Screening

______________________________ ______________________________
First Name Last Name

Date: ____________________

Height: __________________

Weight: __________________

BP: _______________ Temp: ___________ O2: _______________ Pulse: _______________

PLEASE MAKE SURE YOU CHECK ALL THE INFORMATION BELOW YES OR NO:

☐ Yes ☐ No Current Smoker

☐ Yes ☐ No History of Smoking: _____ Number of Years Quit

☐ Yes ☐ No Flu Vaccination: Date Administered _________________

☐ Yes ☐ No Pneumonia Vaccination: Date Administered _________________

☐ Yes ☐ No Breast mammogram / UltraSound: Date _________________

☐ Yes ☐ No Colorectal Screening: Date _________________

Family History:

PLEASE MAKE SURE YOU CHECK ALL THE INFORMATION:

Cancer: ☐ Mother ☐ Father

Heart Disease: ☐ Mother ☐ Father

High Blood Pressure: ☐ Mother ☐ Father