



Patient Name _____

Welcome to Keystone Surgical Associates. Please take a moment to complete this information sheet. If you need assistance in completing this form, please see one of the receptionists at the front desk. Thank you for allowing us the opportunity to care for you today.

What are your current medications? (Including non-prescription drugs)

Medication	Dosage	How Often/Why

Do you have any medication allergies?

Medication	Allergic Response

Have you had any previous surgery, colonoscopy, or hospitalization?

Year	Type of Surgery/ Reason for hospitalization

Do you have a history of any of the following medical conditions?

Hypertension No Yes
 Diabetes No Yes
Cancer No Yes
 Heart Attack No Yes
Liver Disease No Yes
 Bleeding Tendencies No Yes

Do you have any other chronic medical conditions?

Breast History

of Children _____ Age of 1st period _____
 Age at 1st Child/Pregnancy _____ Age of menopause/last period _____

Have you ever had breast surgery? (Please Circle one) YES NO If yes, what year? _____
 Result: _____

Are you currently on hormone therapy? (Please Circle one) YES NO If yes, how long? _____

