

Ken Dixon M.D., FACS

Medical Information Sheet

Name: _____ Date: _____

What physician sent you here today? _____

Who is your family physician? _____

What is the reason for your visit today? _____

Describe your illness or/ symptoms:

How long have you had this problem? _____

What test or treatment have you had regarding this illness? (Medications, x-rays, lab)

Where did you have the test performed? _____

List all surgeries and dates:

List recent (within the last 5 years) hospitalizations, reasons, dates, hospital, and doctor.

What past or present medical illnesses or injuries have you had?

List all the medications you are currently taking and the dosage.

Medication	Dosage	Times taken daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medication, latex gloves or betadine? If so please list _____

What kind of reaction did you have? _____

Patient's Name _____ Date _____

Have you ever had problems with anesthesia? _____

Could you be pregnant? _____

Do you smoke? _____ How much do you smoke? _____

Have you ever smoked? _____ When did you stop smoking? _____

Do you drink alcohol? _____ How often? _____ How much? _____

Do you take aspirin, goody powders or any other aspirin products? _____ How often? _____

Are you married? _____ Do you have children? _____ What are their ages? _____

Do any of these medical illnesses run in your family? If so, list their relationship to you

Cancer Yes___ No___ Family Member _____

Heart Problems Yes___ No___ Family Member _____

Diabetes Yes___ No___ Family Member _____

Asthma Yes___ No___ Family Member _____

Stroke Yes___ No___ Family Member _____

High Blood Pressure Yes___ No___ Family Member _____

Screening

(please circle)

If you are over the age of 50 have you had your colon worked-up? Yes or No

(please circle)

When? _____ What? Flexible sigmoid and BE or Colonoscopy

What were the results? Benign Polyps Other *(please circle)*

If you are over 40 when was your last mammogram?

Was it OK? Yes or No *(please circle)*

Is your PAP smears current? Yes or No *(please circle)*

Release of information

Please list the people who we may give reports to about your medical care? (spouse, family members, friends, etc)

Only the people on this list will be able to call and receive medical information and test results about you.

Name: _____

Review of systems (circle all that apply)

General

Gained or lost weight
Fever or chills

Eyes

Blurred vision
Double vision
Loss of vision

Ears, nose, and throat

Hearing loss
Discharge from nose
Post- nasal drip
Bleeding gums
Sore throat

Cardiovascular

Chest pain
Irregular heart beat
Heart attack
Murmur
Leg swelling
Can't walk up a flight of stairs
Can't sleep flat

Respiratory

Shortness of breath
Wheezing
Cough

Gastrointestinal

Nausea or vomiting
Diarrhea or constipation
Blood in stool
easily
Black stools
Jaundice (yellow skin)

Reproductive (female)

Vaginal discharge or bleeding

Urinary

Trouble urinating
Getting up at night to urinate
Pain or burning

Reproductive (Male)

Blood / discharge from penis
Lump in testicle

Musculoskeletal

Back or joint pain
Stiffness or swelling of joints

Skin

Rash or itching
Worrisome moles or spots

Neurologic

Seizure
Weakness or paralysis

Psychiatric

Feel depressed or anxious

Endocrine

Diabetes

Thyroid

Hematology

Abnormal bleeding
Anemia

Blood clots
Allergic/Immunologic
Hives/hay fever or get infections

Breast

Breast problems

Dr.'s initials _____ Date _____ Updated _____