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GENERAL AND LAPAROSCOPIC SURGERY
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This is a confidential record: Please answer the following questions as completely as you can.
If you are uncertain about a question, leave it blank. Information contained here will not be released without your authority.

Date_____

Patient's Name_____ Age_____

Maiden Name or any other name used?_____

Referring physician's name_____ Phone_____

Primary care physician's name:_____ Phone_____

What symptoms/problems prompted this today? _____

_____

How long have you had this problem?_____ ☐Hours ☐Days ☐Weeks ☐Months☐Years.

Does this problem cause you pain? ☐yes ☐no If yes, describe below:

Where does it hurt?_____

How does it hurt?_____

How severe is it?_____

When does it hurt?_____

What makes it hurt more?_____

What makes it hurt less?_____

Have you had any tests (lab, x-rays, etc.) for this problem? ☐ No ☐ Yes

If yes, which test, when was it done, and where was it done?_____

_____

PAST SURGICAL HISTORY ☐ No Prior Surgeries

	Date if known			
☐ Appendectomy	_____			
☐ Back Surgery	_____	☐ Lower	☐ Neck	
☐ Breast biopsy	_____	☐ Left	☐ Right	
☐ Breast Surgery	_____	☐ Left	☐ Right	
☐ Colon surgery	_____			
☐ Colonoscopy/EGD	_____	☐ polyps		
☐ Gallbladder	_____			
☐ Heart	_____	☐ Pacemaker	☐ Bypass	☐ Stents
☐ Hernia	_____	☐ Left Groin	☐ Right Groin	☐ Umbilical
		☐ Incisional	☐ Epigastric	
☐ Hemorrhoidectomy	_____			
☐ Thyroid	_____			
☐ Hysterectomy	_____			
☐ Tonsillectomy	_____			
☐ Other surgery	_____			

Physician use only:

PAST MEDICAL HISTORY:
Please check any that apply to you.

- ❑ Arthritis
- ❑ Back problems
- ❑ Bladder problems
- ❑ Blood clots in □ legs or □ lungs? Require blood thinners? □ Yes or □ No
- ❑ Blood transfusion
- ❑ Bleeding disorder
- ❑ Cancer? What type or where _____ Did you receive □ chemo □ radiation?
- ❑ High cholesterol or lipids
- ❑ Diabetes □ diet controlled □ on oral medication □ on insulin
- ❑ High blood pressure
- ❑ Liver problems □ Cirrhosis □ Hepatitis, type _____
- ❑ Lung problems □ COPD □ Tuberculosis □ Emphysema □ Asthma □ Sleep apnea □ Shortness of breath □ Other □ Lung cancer
- ❑ Mental health problems □ Depression □ Bipolar □ Dementia □ Other
- ❑ Nerve or neuro problems □ seizures □ migraines
- ❑ Stroke/TIA Any residual deficits? _____
- ❑ Thyroid problems □ on medication
- ❑ Coronary artery disease □ heart attack □ congestive heart failure □ arrhythmia
- ❑ Peripheral vascular disease
- ❑ Skin disorders □ psoriasis □ skin cancer – □basal □squamous □melanoma

FAMILY HISTORY: Do any of your blood relatives (parents, brothers/sisters, grandparents, aunts/uncles/cousins) have or ever had any of the following diseases?

□ None □ Unknown Family History

	Which Relative?
□ Cancer and what type	_____
□ Diabetes	_____
□ Heart Disease/ Problems	_____
□ High Blood Pressure	_____
□ Lung Disease/Problems	_____
□ Stroke	_____
□ Kidney Disease	_____
□ Blood Disease	_____

OCCUPATIONAL/SOCIAL HISTORY:

Birthplace: City _____ State _____

Educational Level: □ HS □ GED □ Some College □ Graduated College
Present Occupation_____
Martial Status: □ married □ single □ divorced □ widowed
Spouse's age_____Spouse's Occupation_____
Spouse's state of health: □ Good □ Fair □ Poor
What church do you attend?_____
Are you willing to accept Blood or Blood products in an emergency? □ No □ Yes
Do you smoke tobacco? □ No □ Yes _____packs per day for _____ years
Do you use smokeless tobacco products? □ No □ Yes What and how much?_____
Do you currently use any form of illegal substances? □ No □ Yes, type?_____
Do you currently consume any alcohol? □ No □ Yes
If yes, how often? □ Daily □ Weekly □ Socially
Type: □ Beer □ Wine □ Liquor

For Physician use only:

Patient's Name_____Date_____

REVIEW OF SYSTEMS Please check any of the following you **currently** or in the **last three months** have experienced.

Constitutional Symptoms:
□ None □ severe headaches □ dizzy spells
□ fatigue □ weakness
□ night sweats □ blood transfusion
□ sensitive to heat/cold
□ trouble with bleeding
□ marked weight □ gain □ loss
other_____

Eyes:
□ None □ trouble seeing □ eye pain/injury
□ cataracts □ wear glasses
□ wear contacts
□ blindness □ right □ left □ both
□ other_____

Ears, Nose, Throat, Mouth:
□ None □ frequent ear infection □ ringing in ears
□ snoring □ sore throat
□ sore mouth/gums □ hoarseness
□ frequent nose bleeds □ dental problems
□ sleep apnea □ use a pap machine
□ pain or difficulty swallowing
□ neck stiffness/swelling/lumps
□ wearing of dentures/partials/caps
□ hearing loss □ right □ left □ both

Breasts:
□ None □ lump(s) □ nipple discharge
□ fibrocystic disease
□ diagnosed with breast cancer
Do you perform monthly self breast exams?
□ Yes □ No
When and where was your last mammogram?
_____

Heart:
□ None □ irregular heart beat □ slow heart rate
□ rapid heart rate □ chest pain
□ palpitations □ pacemaker
□ heart attack □ fainting spells
□ congestive heart failure
□ other_____
Do you have a cardiologist?
□ No □ Yes: Name:_____

Lungs:
□ None □ persistent cough □ productive cough
□ pneumonia □ coughing up blood
□ shortness of breath □ tuberculosis
□ wheezing □ asthma
□ pulmonary embolus □ wheezing
□ other_____

Musculoskeletal:
□ None □ muscle cramps □ muscle weakness
□ generalized aches □ arthritis
□ disc disease □ fibromyalgia
□ joint swelling or pain □ joint stiffness
□ other_____

Gastrointestinal:
□ None □ constipation □ diarrhea
□ gallstones □ heartburn
□ hiatal hernia □ loss of appetite
□ nausea □ vomiting
□ vomiting blood □ black tarry stools
□ jaundice □ stomach ulcer
□ hemorrhoids □ rectal bleeding
□ change in bowel habits
□ other_____

Genitourinary:
□ None □ stress incontinence □ painful urination
□ kidney disease □ dialysis
□ frequent bladder infection
□ difficulty urinating
□ frequent urination □ blood in urine
□ other_____
Males only: Have you ever had a prostate exam?
□ Yes □ No
If yes, when was the last one?_____

Gynecological:
□ None □ irregular periods □ heavy periods
□ pelvic infection □ uterine fibroids
□ ovarian cyst
□ other_____

Skin:
□ None □ new or change in mole
□ skin ulcer
□ change/loss of hair
□ other_____

Endocrine:
□ None □ thyroid problems □ diabetes
□ other_____

Neurological:
□ None □ dementia □ migraines
□ TIA □ multiple sclerosis
□ depression □ seizures
□ anxiety □ sleeplessness
□ poor balance □ memory loss
□ paralysis □ Parkinson's disease
□ numbness □ frequent falls
□ other_____

Patient's Name_____Date_____

Name of person filling out paperwork_____Relationship to patient_____

MEDICATION RECORD

Please list all pharmacies that you currently use to fill your prescriptions.

You may use back of page if needed.

Name of Pharmacy_____ Name of Pharmacy_____

City_____ State_____ City_____ State_____

Pharmacy's Phone#_____ Pharmacy's Phone # _____

ALLERGIES

□ No known allergies □ Latex allergy □ Iodine/Shell Fish

Drug	Reaction

MEDICATIONS

(prescription, over the counter, herbal supplements, etc.)

□ No medications □ List copied and attached

Medication/Strength	Dose/Frequency	Reason for medication

I agree that Jerry Dixon MD may request and use my prescription medication history from other healthcare providers or Third Party pharmacy benefit payers for treatment purposes.

Patient's Signature: _____ Date_____