#3 Medical Park Dr., Suite 201
Benton, AR 72015
Phone: 501-778-3361
FAX: 501-778-3135

GENERAL AND LAPAROSCOPIC SURGERY
JERRY DIXON M.D., F.A.C.S.

www.JerryDixonMD.com

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
☐ 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_____