



DICKSON MEDICAL ASSOCIATES, PC

Physician Name _____

NAME: _____ DOB: _____ Date: _____

Reason for Today's visit _____ How long have you had the problem? _____
 How severe is the problem: Mild _____ Moderate _____ Severe _____ How often are you having the problem? _____
 Does anything contribute to the problem? _____
 Does anything else occur with the problem? _____
 List dates and reasons for your previous hospitalizations: _____

Physician Comments: I have confirmed the above information with the patient and the following are any additional comments: _____

Date of your last colon cancer screening exam (X-ray, flexible sigmoidoscopy or colonoscopy) _____

MEN ONLY: Date of your last prostate exam? _____ Date of your last PSA test? _____ Testicle Pain _____

WOMEN ONLY: How many pregnancies have you had? _____ How many live births? _____ Pain with Periods _____ Irregular Periods _____ Vaginal Discharge _____ Date of your last: mammogram _____ Pap smear _____

LIST OF ONGOING MEDICAL PROBLEMS YES _____ NO _____

Diabetes				Gastrointestinal Problems			
Thyroid Disease				High Blood Lipids or Cholesterol			
Hypertension (High blood pressure)				Arthritis			
Kidney Disease				Drug or Alcohol Treatment			
Sinus or Allergy Problems				Depression or Mental Health Concerns			
Heart Disease				Other:			
Lung Disease							

LIST ANY MEDICATIONS, INCLUDING DOSES THAT YOU ARE PRESENTLY TAKING: _____

Pharmacy and Tel #

LIST ANY MEDICINE ALLERGIES: _____

PLEASE MARK (X) ANY SYMPTOMS THAT YOU CURRENTLY OR INTERMITTENTLY EXPERIENCE:

- Recent Weight Change _____ Fever _____ Fatigue _____ Headaches _____ Eye Disease or Injury _____ Wear contacts or glasses _____ Blurred or Double Vision _____ Glaucoma _____ Hearing Loss _____ Ringing in ears _____ Earache or drainage _____ Sinus problems _____ Nose bleeds _____ Mouth sores _____ Bleeding Gums _____ Bad breath or bad taste _____ Sore throat or voice changes _____ Swollen glands _____ heart trouble _____ Chest pains _____ Sudden change in heart beat _____ Swelling in feet, ankles or hands _____ Frequent coughing _____ spitting up blood _____ Shortness of breath _____ Asthma or wheezing _____ Loss of appetite _____ Change in bowel movement _____ Nausea or vomiting _____ Frequent Diarrhea _____ Painful bowel movements or constipation _____ Blood in stool _____ Stomach pain _____ Frequent urination _____ Burning or painful urination _____ Change in force or stream _____ Blood in urine _____ Incontinence or dribbling _____ Kidney stones _____ Joint pain _____ Joint stiffness or swelling _____ weakness of muscles or joints _____ Muscle pain or cramp _____ Cold extremities _____ Difficulty walking _____ Rash or itching _____ change in skin color _____ change in nails or hair _____ Varicose veins _____ Breast pain, lump or discharge _____ Frequent headaches _____ Light headed or dizzy _____ Convulsions or seizures _____ Tremors _____ Paralysis _____ Stroke _____ Memory loss or confusion _____ Nervousness _____ Depression _____ Sleep problems _____ Glandular or hormonal problem _____ Thyroid Disease _____ Excessive thirst or urination _____ Heat or cold intolerance _____ Dry Skin _____ Slow to heal after cuts _____ Easily bruise or bleed _____ Anemia _____ Phlebitis _____ Past transfusions _____ Enlarged Glands _____

Other symptoms or concerns:

If you are working outside the home, what is your job or profession? Are you happy there?

What are your hobbies? _____ How do you exercise and how often? _____

Are you Married __ Single __ Divorced __ Separated __ Widowed __ Do you have children? _____

Use of Alcohol: Never __ Rarely __ Moderate __ Daily __

Use of Tobacco: Never __ Previously, but quit __ Current packs per day _____

Use of Drugs: Never __ Type/Frequency _____

Seat Belt usage: Never __ Rarely __ Moderate __ Daily __

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Excessive Exposure at work or home to: Fumes __ Dust __ Solvents __ Noise __

VACCINES:

- Tetanus in the last 10 yrs? _____
- Pneumonia in the last 5 yrs? _____
- Hepatitis B vaccine (3 shots)? _____
- All childhood immunizations? _____
- Positive TB skin test in the past? _____

ADVANCED MEDICAL DIRECTIVES

- Do you have a Living Will and/or Durable Power of Attorney for health care? _____
- If not, would you like some information? _____
- Are you willing to be an organ donor? _____
- If yes, do you have an organ donor card? _____