

# DEKALB SURGICAL ASSOCIATES, P. C.

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## MEDICAL INFORMATION

Name \_\_\_\_\_

Today's Date \_\_\_\_\_

Reason for your visit \_\_\_\_\_

Your primary physician \_\_\_\_\_

Did he/she refer you to us: Yes No (circle)

If no, who referred you to us? \_\_\_\_\_

If you have had any of the following medical problems with or without surgery, **please check or circle** and describe below:

**For additional comments:**

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Bleeding disorders	_____
<input type="checkbox"/> Heart attack/ <input type="checkbox"/> Angina/ <input type="checkbox"/> Heart failure	<input type="checkbox"/> Blood clots/Phlebitis	_____
<input type="checkbox"/> Lung trouble/ <input type="checkbox"/> emphysema	<input type="checkbox"/> High cholesterol	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes On insulin? Dose: _____	_____
<input type="checkbox"/> Liver trouble/ <input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Arthritis/ Gout	_____
<input type="checkbox"/> Stomach ulcers When? _____	<input type="checkbox"/> Thyroid trouble	_____
<input type="checkbox"/> Kidney trouble Type: _____	<input type="checkbox"/> Hernia	_____
<input type="checkbox"/> Cancer Type: _____ When diagnosed? _____	<input type="checkbox"/> Gallbladder/ Pancreas trouble	_____
<input type="checkbox"/> Epilepsy/ <input type="checkbox"/> Seizure/ <input type="checkbox"/> Stroke	<input type="checkbox"/> Acid reflux/ Heartburn	_____
<input type="checkbox"/> Anemia None		

For all patients over 50: I have had stool tests for hidden blood. Yes No (circle)

I have had flexible sigmoidoscopy or colonoscopy within the past 10 years. Yes No (circle)

For women over 40: I have had a screening or diagnostic mammogram within the past year. Yes No (circle)

When was your last mammogram? \_\_\_\_\_

For all men over 50: I have had a prostate blood test (PSA). Yes No (circle)

**OTHER MEDICAL PROBLEMS** - Please List

**PREVIOUS SURGERY WITH DATES:** - Please List ALL

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS:** Dosage How Often (Please list)

(include any over-the-counter meds and nutritional supplements

taken regularly, **especially aspirin**)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:** Please check all that apply

<input type="checkbox"/> None	<input type="checkbox"/> Codeine
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine dye	<input type="checkbox"/> Latex (rubber)
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Other (Please list)
<input type="checkbox"/> Tape	

Other: \_\_\_\_\_

**PH:** Do you do any regular exercise? No \_\_\_ Yes \_\_\_ Describe: \_\_\_\_\_

Do you smoke: No Yes Used to (circle) How many packs per day? \_\_\_ For how many years? \_\_\_ Stop date? \_\_\_\_\_

Do you drink alcoholic beverages? No Yes Used to (circle) On average I have \_\_\_ drinks/ beers each (circle) day / wk

Have you ever been tested for AIDS, HIV or hepatitis? Yes No (circle) If yes, when? \_\_\_\_\_

**FOR DOCTOR'S USE ONLY:**

NI Abnl

**ROS:** Gen:  
CV/ Resp:  
GI/GU:  
MS/Neuro:  
Hem: