Ronald L. Dotson M.D., P.A.

PATIENT MEDICAL INFORMATION SHEET

Please help us to better care for you by filling this form out as accurately and completely as possible. The information you put on this form helps Dr. Dotson know your medical history better so that he can better help you take care of yourself. If there is any question you don't understand or are unsure of how to answer, please be sure to ask for help. Thank you for choosing Dr. Dotson.

DATE:_____NAME:_____ AGE:____ DOB:_____

Allergies to medicine or food:_____

MENSTRUAL HISTORY:

Date of first day of last period:_____ Age when you had your first period:_____
How many days between your periods (first day of one to the first day of the next)?_____
How long does your period usually last?_____ Pain with periods: None☐ Mild☐ Moderate☐ Severe☐
Number of pads/tampons used in a 24-hour period of heaviest flow: Pads_____ Tampons_____
Any premenstrual symptoms (PMS)?_____ If yes, describe:_____

PREGNANCY HISTORY:

Number of times *ever* pregnant:_____ Number of live births:_____ Number of miscarriages:_____
Number of abortions:_____ Have you had problems getting pregnant?_____

Tell us about your pregnancies:

Year	How far along at delivery	Baby's Sex	Baby's Wt.	Problems with baby	Problems during pregnancy and/or delivery and type of delivery(vaginal or c-section)

PAP SMEAR / MAMMOGRAM HISTORY:

Date of last Pap smear:_____ Normal____ Abnormal____ HPV test done?_____ Results and when?_____Have you ever had treatments for an abnormal Pap smear?_____ If yes, when and describe:_____

Have you had a mammogram?_____ If yes, when was last one?_____ Have you had treatments for breast lumps or other breast problems?_____ If yes, when and describe:_____
Is there a family history of breast cancer?_____ If yes, who:_____

SEXUAL HISTORY / CONTRACEPTIVE HISTORY:

Age at first time for sex:_____ History of sexual abuse:_____ Decreased sex drive:_____
How many sexual partners have you had in your lifetime? none_____ 1-4_____ 5 or more_____
Are you currently with only one partner?_____ Any sexual problems or issues you would like Dr. Dotson to address?_____
_____

Check all methods that you have ever used to prevent pregnancy:

1. **None ☐**
2. **IUD ☐**
3. **Condoms ☐**
4. **Spermicides ☐**
5. **Withdrawal ☐**
6. **Cervical cap ☐**
7. **Diaphragm ☐**
8. **Natural family planning ☐**
9. **Birth control pills or patches ☐**
10. **Depo Provera injections ☐**
11. **Norplant ☐**
12. **Tubal ligation / Vasectomy ☐**

What method are you currently using?_____
How long have you been using contraceptives?_____ Are you currently trying to get pregnant?_____
If yes, for how long?_____
If no, what method of birth control do you want to use now?
_____
_____

PERSONAL MEDICAL HISTORY (please check anything you personally have or had):

YES	NO		YES	NO		YES	NO	
☐	☐	Diabetes	☐	☐	Viral illness (hepatitis, etc.)	☐	☐	Anemia
☐	☐	Heart disease	☐	☐	Clots in lungs or veins	☐	☐	Epilepsy
☐	☐	Stomach / intestine problems	☐	☐	Bleeding disorders	☐	☐	Liver disease
☐	☐	Breast disease/lumps	☐	☐	Bone or joint disorders			
☐	☐	Thyroid ☐ Low ☐ High	☐	☐	High blood pressure			
☐	☐	Bladder or kidney problems	☐	☐	Lung disorders/Asthma			
☐	☐	Malaria/tropical diseases	☐	☐	Emotional disorders:_____			
☐	☐	Cancer—type:_____						
☐	☐	Infection of uterus / tubes / ovaries—when and how treated:_____						
☐	☐	History of STD's: Gonorrhea ☐, Chlamydia ☐, Herpes ☐, Genital warts ☐, Syphilis ☐, AIDS ☐ (check)—when and how treated: _____						
☐	☐	Did your mother take a hormone during her pregnancy with you to prevent miscarriage (called DES)?						

CURRENT MEDICATIONS AND DOSAGES—Please be as complete as possible, including over the counter meds, vitamins, herbal and nutritional supplements, even if not taken regularly:

_____ _____
_____ _____
_____ _____

Do you smoke cigarettes?_____ If yes, how may packs/day:_____ For how long:_____
Do you drink alcohol?_____ If yes, how much and how often:_____
Do you use illicit or street drugs (marijuana, cocaine, etc.)?_____ If yes what type and amount:_____
Have you used illicit drugs in the past?_____ If yes, when and what type:_____

PAST HOSPITALIZATIONS AND SURGERIES:

Date	Reason for admission

Patient Name:_____ **Date of Birth:**_____

FAMILY MEDICAL HISTORY: (Please indicate mother or father side of family in description area)

YES	NO		YES	NO	
☐	☐	**Diabetes**_____	☐	☐	**High blood pressure**_____
☐	☐	**Heart disease**_____	☐	☐	**Liver disease**_____
☐	☐	**Stomach / intestinal disorders**_____	☐	☐	**Lung disorders**_____
☐	☐	**Bleeding disorders**_____	☐	☐	**Emotional problems**_____
☐	☐	**Breast disease / lumps**_____	☐	☐	**Bone and joint problems**_____

REVIEW OF CURRENT SYSTEMS:

Do you have any of the following complaints at this time? Please describe, including how long and treatments used.

YES	NO	
☐	☐	**Fever, chills, night sweats:**_____
☐	☐	**Vision problems:**_____
☐	☐	**Problems with head or neck, frequent headaches, dizziness:**_____
☐	☐	**Problems with ears, nose, or throat, hay fever, allergies:** _____
☐	☐	**Chest pain, shortness of breath, heart problems:**_____
☐	☐	**Lung problems/asthma:**_____
☐	☐	**Stomach or intestinal problems, nausea, vomiting, constipation, or diarrhea:**_____
		_____
☐	☐	**Bladder or kidney problems, leakage of urine, burning, pain, or urgency with urination:**_____
		_____
☐	☐	**Pelvic pain, pain or bleeding with intercourse, painful periods:**_____
☐	☐	**Vaginal discharge (color, consistency, odor, itching or burning, how long):**_____
		_____
☐	☐	**Breast pain or lumps:**_____
☐	☐	**Joint pain or muscle weakness:**_____
☐	☐	**Skin problems, rashes:**_____
☐	☐	**Neurological problems, seizures, strokes, loss of memory:**_____
☐	☐	**Difficulty sleeping, increased stress, depression, anxiety, sadness, suicidal thoughts-please describe:**_____
		_____
☐	☐	**Family problems:**_____
☐	☐	**Work problems:**_____
☐	☐	**Heat or cold intolerance, fatigue, recent significant weight change:**_____
☐	☐	**Anemia, easy bruising:**_____

Please list any comments, questions, or concerns you would like to discuss with Dr. Dotson:

Patient Name:_____ **Date of Birth:**_____