NAME: ________________________

DATE OF BIRTH: ___________

TODAYS DATE: ____________

Andrew Parker, MD
1120 Raintree Circle, Suite 280
Allen, TX 75013
Phone: (214) 383 – 9356

Who referred you to us today/How did you find us?____

Primary Care Physician: ____ Phone: _____________________

Preferred Pharmacy: ____________________________ Location: ___________________ Phone: ________________

Occupation: _______________________________ Hand dominance: RIGHT LEFT

Are you currently under pain management? NO YES - DOCTOR: _______________________

CURRENT MEDICATIONS: (please list all current medications including aspirin and supplements, use back if more space needed)

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY
1)			4)		
2)			5)		
3)			6)		

DRUG ALLERGIES: NO YES - LIST: ____

LATEX ALLERGY: NO YES IODINE ALLERGY: NO YES

PREVIOUS HOSPITALIZATIONS/SURGICAL PROCEDURES (please provide dates to the best of your ability):

SURGERY/REASON FOR HOSPITALIZATION	YEAR	SURGERY/REASON FOR HOSPITALIZATION	YEAR
1)		3)	
2)		4)	

FAMILY MEDICAL HISTORY:

	Father	Mother	Siblings	Children		Father	Mother	Siblings	Children
Arthritis					High blood pressure/cholesterol				
Osteoporosis					Cancer				
Diabetes					Other:				

SOCIAL HISTORY: SINGLE MARRIED DIVORCED WIDOWED OTHER

ALCOHOL: NEVER RARELY WEEKLY DAILY HEAVY

TOBACCO: NEVER FORMER OCCASIONAL DAILY (_____Packs Day) Year started: ______

DRUGS: NEVER FORMER CURRENT - (MARIJUANA OTHER: ____________________)

REVIEW OF SYSTEMS/GENERAL HISTORY:

HEIGHT: _____________ WEIGHT: _______________ USUAL BLOOD PRESSURE (IF KNOWN): _______/_______

GENERAL			GASTROINTESTINAL			RESPIRATORY		
Weight change	YES	NO	Difficulty swallowing	YES	NO	Cough/sputum	YES	NO
Fever or chills	YES	NO	Jaundice	YES	NO	Shortness of breath	YES	NO
Night sweats	YES	NO	Hepatitis	YES	NO	Asthma	YES	NO
Bleeding	YES	NO	Reflux	YES	NO	Emphysema/COPD	YES	NO
Lumps or Masses	YES	NO	Gastric ulcers	YES	NO	Sleep apnea	YES	NO
Dizziness or Fainting	YES	NO	CARDIOVASCULAR			GENITOURINARY		
Cancer	YES	NO	Chest pain	YES	NO	Urinary infections	YES	NO
(type: _______________)			Heart disease	YES	NO	Incontinence	YES	NO
EAR-EYE-NOSE-THROAT			High blood pressure	YES	NO	Urinary frequency	YES	NO
Vision change	YES	NO	Atrial fibrillation	YES	NO	Veneral disease	YES	NO
Hearing change	YES	NO	Defibrillator/pacemaker	YES	NO	Menopause	YES	NO
Ringing in ears	YES	NO	Stents	YES	NO	Kidney disease	YES	NO
MUSCULOSKELETAL			Heart failure	YES	NO	Dialysis	YES	NO
Joint pain	YES	NO	Mitral valve prolapse	YES	NO	PSYCHOLOGICAL		
Joint swelling	YES	NO	Blood clots/DVT	YES	NO	Depression	YES	NO
Back pain	YES	NO	NEUROLOGICAL			Bipolar	YES	NO
Rheumatoid Arthritis	YES	NO	Seizures	YES	NO	ADHD	YES	NO
ENDOCRINE			Numbness	YES	NO	Other __________________		
Diabetes Type 1	YES	NO	Weakness	YES	NO	INFECTIOUS DISEASE		
Diabetes Type 2	YES	NO	SKIN			Hepatitis C	YES	NO
Thyroid Problem	YES	NO	Rash	YES	NO	HIV/AIDS	YES	NO
Other ______________________			Itching	YES	NO	Tuberculosis	YES	NO

Do you have a personal or family history of malignant hyperthermia? YES NO | MRSA YES NO

Have you ever had complications with anesthesia? YES NO

Will you accept a blood transfusion if necessary? YES NO

____

PATIENT SIGNATURE (if over 17 years old) DATE

PHYSICIAN REVIEW

____

SIGNATURE DATE