

# Drisko, Fee & Parkins, P.C.

## PATIENT MEDICAL HISTORY

(Please print or hit tab to jump to the next field)

Name		Age		Today's Date:	
Dominant Hand <input type="checkbox"/> Right <input type="checkbox"/> Left		Marital Status (Check One)		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow	
Occupation (if retired, former occupation)			Date symptoms began		
List current symptoms					
What treatment, if any, have you had for these symptoms?					
Have X-Rays been taken?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Date	
				By whom?	

### MEDICAL HISTORY

Disease or Disorder	You	Family	Disease or Disorder	You	Family
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Vein Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Bowel	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Other Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Anesthesia Problems	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Other Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any risks factors for HIV (such as blood transfusions, IV drug use, multiple sexual partners, homosexual encounters, or partners who have used IV drugs, etc)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been tested for HIV?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Date	<input type="checkbox"/> Positive <input type="checkbox"/> Negative

1. List all past operations, serious illnesses & hospitalizations, including dates:

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2. List all medications you are currently taking. Please indicate dosage, times per day and reason for the medication. If none at this time, please state "None". Please include over the counter medications and herbal medications in this list:

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3. List any allergies to medications or foods and the reaction they cause

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4. Do you use alcohol?  Yes  No What type? How often?  
 Do you use tobacco?  Yes  No What type? How often?  
 Do you use illicit drugs?  Yes  No What type? How often?

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5. **Family History**  
 Father Living?  Yes  No If no, cause of death  
 Mother Living?  Yes  No If no, cause of death  
 Siblings Living?  Yes  No If no, cause of death  
 Children Living?  Yes  No If no, cause of death