Darrell Parsons, M.D., P.A.
318 N. Alleghaney, Suite 100
Odessa, Texas79761
432-640-2929

Date: _____

Medical History Form

_____,_____
Last Name First Name Middle Name

Date of Birth:_____ Medical Record Number(staff to complete):_____

Reason to see the doctor today (brief):

_____

_____

Medications: Please list the name of your medications, the dosage and number (amount) taken (schedule).

Medication Name Dosage (milligrams) Number and Schedule per Day, Week, or Month

_____

_____

_____

_____

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_____

_____

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_____

_____

Allergies: List any medication to which you are allergic and (if known) the reaction:

Name of medication: Reaction:

_____

_____

_____

_____

_____

_____

Name (last,first):_____MR#_____

Past Medical History: Please indicate whether you have had any of the following medical problems:

□Acid Reflux
□ Alcoholism
□Anemia
□Anxiety
□Aortic aneurism
□Asthma
□Autoimmune Disorder
□Bleeding Problems
□Blood Transfusion
□Cancer
□Carotid artery disease
□Chronic Dental Problems
□Colon polyps
□Congestive Heart Failure
□Depression
□Diabetes
□Diverticulosis–itis
□Drug addiction
□Elevated glucose
□Emphysema or COPD
□Fatty liver
□Fracture as an adult
□Gout
□H. Pylori Infection
□Heart Disease
□Heart irregularity
□Heart murmur
□Hepatitis
□High blood pressure
□High Cholesterol
□Kidney disease
□Lupus
□Migraine
□Osteoarthritis
□Osteoporosis
□Polycystic ovaries
□Poor blood flow to legs
□Psoriasis
□Rheumatoid arthritis
□Seizure disorder
□Sleep apnea
□Stroke warning (TIA)
□Stoke
□Thyroid problems

Please list any medical problems not on the list above:_____

_____

_____

_____

Please list recent hospitalizations for illness other than surgery:

Illness	Approximate Date	Hospital

Surgery: Please list operations including angiograms or stents:

Procedure	Approximate Date

Social History:

Tobacco use:
Cigarettes: □ Never
□ Former: Quit date: _____ I smoked _____ packs/day for _____years
□ Current: Packs or number smoked per day_____
Other tobacco: □ Pipe □ Cigar □ Chew/Snuff Number of years used: _____
Second hand smoke exposure □ No □ Yes
Alcohol use: Do you drink alcohol? □ No □ Yes #of drinks/week:_____
Illicit drugs: □ No □ Yes:_____
□ Past Use: _____

Name (last,first):_____MR#_____

Sexual History:

Male: Do you have any problems with erections: □ No □ Yes: Date of onset:_____

Female: History of gestational diabetes: □ No □ Yes

Socioeconomic:

Marital status: □ S □ M □ D □ W Occupation:_____

Family History

Beside each condition below please list the family members (parents, siblings or children) who have suffered from the condition and the estimated age diagnosed. Include living or deceased members. See example:

Heart Disease	Mother, 79	Brother, 55	Sister, 59

CONDITION	RELATION, AGE	RELATION, AGE	RELATION, AGE
Alcoholism			
Alzheimer's			
Anemia			
Aortic Aneurysm			
Arthritis/Rheumatoid			
Asthma			
Autoimmune Disorder			
Bleeding Disorder			
Cancer of Breast			
Cancer of Colon			
Cancer of Prostate			
Carotid Artery Disease			
Depression			
Diabetes			
Gout			
Heart Disease, Angina			
Heart Failure			
Heart Arrhythmia			
High Blood Pressure			
High Cholesterol			
Kidney Disease or Failure			
Leukemia/Lymphoma			
Osteoporosis			
Peripheral Artery Disease			
Seizure Disorder			
Sleep Apnea			
Stroke			
Thyroid Condition			
Other:			
Other:			
Other:			
Other:			