James A. Parker, M.D.
1181 Langford Drive | Watkinsville, GA 30677
706.543.0404
www.parkerplasticsurgery.com

Please fill out form completely – Do not leave any spaces blank – If it does not apply, please write in "N/A"

Name _____ Date _____

Date of Birth _____/_____/_____ Height _____ Weight _____ Age _____

Primary Care Physician _____

Reason for today's visit _____

Allergies (Any meds you cannot take?)_____

Date of injury/first symptom _____/_____/_____ Is condition/injury work related? Yes_____ No_____

Do you have a hospital preference? (circle one) Athens Regional St. Mary's No Preference

List previous surgeries and dates if known _____

_____

_____

Have you or any family member ever had complications related to anesthesia including high fever?_____

List all current medications (include aspirin, birth control, vitamins)_____

_____

_____

Past Medical History: Have you ever had the following…

	NO	YES		NO	YES		NO	YES
Anemia	☐	☐	Heart murmur	☐	☐	Poor circulation	☐	☐
Cancer	☐	☐	Irregular heart beat	☐	☐	Seizure	☐	☐
If Yes, type _____			Thyroid problems	☐	☐	Bowel/stomach disorders	☐	☐
Diabetes	☐	☐	Hepatitis	☐	☐	Emphysema/COPD	☐	☐
High blood pressure	☐	☐	Keloids/excessive scaring	☐	☐	Bronchitis	☐	☐
Kidney disease	☐	☐	Rheumatic fever	☐	☐	Cough > 3 wks	☐	☐
Stroke	☐	☐	Ulcers	☐	☐	Prosthesis	☐	☐
Asthma	☐	☐	Arthritis	☐	☐	Jaundice	☐	☐
Heart disease	☐	☐	Excessive bleeding	☐	☐	Other _____		

Family History: Has any blood relative had the following…

	NO	YES		NO	YES		NO	YES
High blood pressure	☐	☐	Heart disease	☐	☐	Kidney disease	☐	☐
Melanoma	☐	☐	Cancer	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	If Yes, type _____			Other _____		

Reviews of Systems: Do you have or have you had in the last year…

	NO	YES		NO	YES		NO	YES
Weight change	☐	☐	Swollen ankles/feet	☐	☐	Seizures	☐	☐
Dry eyes	☐	☐	Skin rash	☐	☐	Joint or muscle problems	☐	☐
Chronic cough	☐	☐	Chronic diarrhea	☐	☐	swollen lymph nodes	☐	☐
Chest pain	☐	☐	Jaundice	☐	☐	Easy bleeding	☐	☐
Rapid heart beat	☐	☐	Depression	☐	☐	Easy bruising	☐	☐
Sinus problems	☐	☐	Urinary problems	☐	☐	Other _____		

Do you smoke/use tobacco products? ☐ Yes ☐ No Packs/Day _____ Other _____

Do you drink alcohol? ☐ Yes ☐ No Drinks/Day _____

Is there any chance that you are pregnant? ☐ Yes ☐ No

I verify that the above information is true and accurate to the best of my knowledge.

X _____ _____

Signature of Patient/Responsible Party Date