Sheela Parrish , M.D. P.C.

Name: ____ Date: _________________________

Date of birth: _______________ Age: _________ Previous Physician: _______________________

Any new or worsening problems? If yes, please describe: __________________________________

Please Check and/or Circle if you have had any of the below currently or in the past:

☐ Abnormal Pap Smear
☐ Alcohol Addiction
☐ Allergic Rhinitis
☐ Asthma
☐ Atrial Fibrillation
☐ Anemia (Low Iron or Low B12)
☐ Anxiety
☐ Auto Immune Disease (Lupus, Rheumatoid Arthritis, ETC)
☐ Bipolar
☐ Blood Transfusion
☐ Breast Disease
☐ Cancer of any type
☐ Cataract
☐ Celiac Disease
☐ Cirrhosis
☐ Clotting Disorder
☐ CVA/Stroke
☐ COPD (Lung Disease)
☐ Coronary Heart Disease
☐ Chron's Disease / Ulcerative Colitis
☐ Depression
☐ Diabetes (Type 1 or 2)
☐ Drug Addiction
☐ DVT (Blood Clot in Legs)
☐ GI Bleed
☐ GERD (Acid Reflux)
☐ Gestational Diabetes
☐ Glaucoma
☐ Heart Disease (Stent, Bypass)
☐ Hemochromatosis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV
☐ Hepatitis (A, B, or C)
☐ Infertility
☐ Kidney Disease (Renal Failure, Etc)
☐ Kidney Stones
☐ Liver Disease
☐ Memory Difficulty
☐ Mental Illness
☐ MI (Heart Attack)
☐ Migraines
☐ Neurologic Disorder (Parkinson's Disease, Alzheimer's, etc)
☐ Osteoarthritis
☐ Osteopenia
☐ Osteoporosis
☐ Prostrate Issues
☐ Prostrate Issues
☐ PUD (Stomach Ulcers)
☐ Seizure Disorder
☐ Sexually Transmitted Infection
☐ Sleep Apnea
**Using CPAP? ☐Yes ☐No
☐ Thyroid Disorder
☐ Tuberculosis
☐ Valvular Heart Disease
☐ Varicose Veins/Phlebitis
☐ Vascular Disease

Other:____

SOCIAL HISTORY: (Check Appropriate)

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Sexual Partners: ☐ Male ☐ Female ☐ Both ☐ N/A

Employment: ☐ Part Time ☐ Full Time ☐ Retired ☐ Disabled Occupation: ______________________

If not currently working, Previous or Former Occupation: ___________________________

Children: ☐ Yes ☐ No Number of pregnancies: _____ Children delivered: ________

Prior Military Service: ____

Religious Preference: ____

Sheela Parrish, M.D. P.C. Affiliated with Madison Family Medicine
8371 Highway 72 W, Suite 200 Madison, AL 35758 Phone: 256.722.0664 Fax: 256.722.0285

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RISK FACTORS:

Tobacco Use: ☐ Current ☐ Former ☐ Never
How many years: ___________________________ How many packs per day: ________________
If current, year Started: ____________________ If former, year quit: _______________
Type of Tobacco: ☐ Cigarettes ☐ Cigars ☐ Snuff ☐ Vapor ☐ Chew

Caffeine Use: ☐ Yes ☐ No How many per day: _____________ Type of caffeine: _______________
Alcohol Use: ☐ Yes ☐ No How many per day: _____________ Type of alcohol: ________________
Marijuana Use: ☐ Yes ☐ No How often: ____

Any history of recreational, IV, or other drug use? ☐ Yes ☐ No
If yes, please give details: ____

Received a Blood Transfusion: ☐ Yes ☐ No
Received a tattoo: ☐ Yes ☐ No
Been intimate with anyone who has tattoos: ☐ Yes ☐ No
Any evidence of Hepatitis: ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No Times per week? _____ What kind? ______________________________

Past Surgical History: (Please write dates beside surgery)

☐ Appendectomy
☐ Back Surgery
☐ Breast Surgery
☐ CABG (Heart Bypass)
☐ Carotid Endarterectomy
☐ Carpel Tunnel
☐ Gallbladder Removed
☐ Colon Resection
☐ Gastric Bypass /Sleeve
☐ Heart Valve Surgery

☐ Hemorrhoidectomy
☐ Joint Replacement
☐ Joint Surgery
☐ Kidney Transplant
☐ Knee Arthroscopy
☐ Nephrectomy (Kidney Removed)
☐ Pacemaker Implanted
☐ Parathyroidectomy
☐ Pneumonectomy
☐ Hysterectomy/Overies

*Ovaries Removed ☐ Yes ☐ No
Reason:____________________
☐ Prostate Surgery
☐ Sinus Surgery
☐ Sleep Apnea Surgery
☐ Thyroid Surgery
☐ Tonsils Removed
☐ Vascular Surgery

Other: ____

FAMILY HISTORY:

	Father	Mother	Siblings	Children	Grandparents
High Blood Pressure	☐	☐	☐	☐	☐
Heart Disease/ Heart Attack	☐	☐	☐	☐	☐
Kidney Disease (Chronic)	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐
Genetic Disorder	☐	☐	☐	☐	☐
Clotting Disorder	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐

Name:______________________________ Date:_______________

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(TYPE OF CANCER): ____

PREVENTIVE MEDICINE:

What is the date of your last physical exam:__________ **Findings:**____

Performed by: ______________________________________

Year of last:

Tetanud vaccine: ________ **Flu vaccine:** _______ **Pneuovax:** ________ **Prevnar:** ________ **Shingles vaccine:** ________

Have you had a colonoscopy? If yes, what year? ______ **Results/Findings:** ___________________________________

Have you been diagnosed as a diabetic? ☐ Yes ☐ No

If yes,

Date of Last Eye Exam: _______________________ Abnormalities: ___________________________

Date of Last Foot Exam: _______________________ Abnormalities: ____________________________

Females: Year of last: Mammogram_________________ Pelvic Exam _____________ Bone Density ______________

History of abnormal pap: ☐ Yes ☐ No Last menstrual period: _____________

Males: Year of last: Prostrate Exam: _________________________ Abnormalities? ___________________________

PSA (prostrate screen): ____________________ Abnormalities? ___________________________

PLEASE LIST ANY SPECIALIST YOU HAVE SEEN: ☐ I HAVE NOT SEEN ANY SPECIALIST

Type of Specialist:	**Name:**

ALLEERGIES OR MEDICATION REACTION: ☐ NO KNOWN DRUG ALLERGIES

Alergic To:	**Reaction:**

Name:______________________________ Date:_______________

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CURRENT MEDICATIONS, VITAMINS, & SUPPLEMENTS: ☐ Refer to list ☐ Refer to Bottles

Please include the dose and how often you take the medicine (no need to list if you brought in a list or bottles)

Name	Dosage	How many times per day	As needed (PRN)

SYMPTOMS: Have you had any recent or persistent problems with the following?

General
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Weight loss/gain

Eyes
- ☐ Vision changes
- ☐ Double vision
- ☐ Eye pain
- ☐ Glasses/contacts

HENT
- ☐ Hearing Changes
- ☐ Ringing in ears
- ☐ Sinus trouble
- ☐ Nose bleeds
- ☐ Sort throat
- ☐ Hoarseness
- ☐ Dizziness

Cardiovascular
- ☐ Chest Pain
- ☐ Chest tightness
- ☐ Irregular beat
- ☐ Rapid heartbeat
- ☐ Ankle swelling
- ☐ Varicose veins
- ☐ Elevated blood pressure

Pulmonary
- ☐ Persistent cough
- ☐ Wheezing
- ☐ Blood in sputum
- ☐ Shortness of breath
- ☐ Painful breathing

GastroIntestinal
- ☐ Poor appetite
- ☐ Swallowing Problems
- ☐ Heartburn
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Bloating
- ☐ Excessive thirst
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Stomach pain
- ☐ Blood in stools
- ☐ Change in stools
- ☐ Tarry stools

Genitourinary
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Can't hold urine
- ☐ Can't urinate
- ☐ Weak stream
- ☐ Going too often
- ☐ Increased night time urination
- ☐ Discharge

Women:
- ☐ Irregular periods
- ☐ Pelvic pain
- ☐ Lumps in breast

Neurological
- ☐ Weakness on one side
- ☐ Headache
- ☐ Fainting
- ☐ Seizures
- ☐ Loss of balance
- ☐ Tremor
- ☐ Numbness
- ☐ Memory problems

Musculoskeletal
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Joint deformity
- ☐ Muscle pain/spasms
- ☐ Weakness
- ☐ Muscle cramps

Skin
- ☐ Rashes
- ☐ Nail/hair problems
- ☐ Itching
- ☐ Sores
- ☐ Lumps
- ☐ Moles
- ☐ New lesion
- ☐ Change in lesion

Psychiatric
- ☐ Change in mood
- ☐ Loss of pleasure
- ☐ Can't sleep
- ☐ Too much energy
- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal

Name:______________________________ Date:_______________

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