

LINDA I. PARKER, M.D.

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Name _____ Date First Seen _____
Last First M

Date of Birth _____ Place of Birth _____

Family Hx.	Birth Date	State of Health		Education: HS C. PG		
Father						
Mother						
Pat.				Religion: _____		
Mat				Hospitalizations & Operations:		
Sisters & Brothers						
Spouse						
Children						
Have you or any relative (blood) or husband/wife had:	SELF		RELATIVE		Relationship	Critical Remarks:
	NO	YES	NO	YES		
Diabetes						
Cancer						
Anemia						
Gout						
Kidney Disease						
High Blood Pressure						
Heart Trouble						
Bleeding Disorder						
Asthma Hay Fever						
Seizures						
Mental Retardation						
Malformation						
Neurologic Disease						Menstrual History: No. of Children _____
Stroke						Length _____ Cramps _____ Weight of Heaviest Child _____
Blindness						Age Menses Began _____ Clots _____ No. Of Pregnancies _____
Thyroid Problem						Frequency _____ Miscarriages _____
Deafness						Smoking History:
Venereal Disease						Age Started _____ Cigarettes _____ Cigars _____ Pipe _____
Mental Illness						Age Stopped _____ Quantity _____ Packs / Day
Stomach or Bowel Problems						Reason for Stopping _____
Rheumatic Fever						Allergies:
Tuberculosis						
Glaucoma						
Arthritis						
Operations						Alcohol Use:
Hospitalization						Age Started _____ Quantity _____
Injuries						Age Stopped _____
Hepatitis-Jaundice						Reason for Stopping _____
Pneumonia						
Tonsillitis						
Measles						