HD ___/___

John Parkerson, M.D., M.S.

4717 Falls Road, Baltimore, MD 21209
410-366-3627

TODAY'S DATE________________________________2025 ARR Time ____________
Month Day

NAME____
Last Suffix First Middle Initial

GENDER Male Female Right Handed Left-Handed Ambidextrous

ADDRESS ____
Street City State Zip Code

TELEPHONE _____- _____-_______ SOCIAL SECURITY NUMBER (last 4 digits) __________
Area Code

AGE I am _____ years old. DATE OF BIRTH ___________________________
Month Day Year

ALLERGIES Seasonal Penicillin OTHER ___________________________

CURRENT MEDICATIONS (by prescription or over-the-counter) or I have a list that can be copied

____

CURRENT MEDICAL PROBLEMS such as High Blood Pressure Asthma Heart Sleep Apnea Diabetes High Cholesterol OTHER

____

____

OPERATIONS such as Hernia Tonsillectomy Appendectomy Vasectomy Hysterectomy Tubal Ligation Gall Bladder Cataract Bunion Sinus

OTHER (type of operation and year) ____

____

____

FR EM HG LA FILE 8___ ___ ___

NAME____
Last Suffix First Middle Initial

CURRENT TREATING PHYSICIANS ____

HOSPITALIZATIONS (reason for admission and year)____________________________________

____

WORK INJURIES (part injured and year) ____

____

MOTOR VEHICLE ACCIDENTS and OTHER INJURIES (part injured and year) _________________

____

TOBACCO USE None Quit Smoking Year ________ Less than 1 pack per day
1 pack per day More than 1 pack per day Cigars Pipe Chew Vape

ALCOHOL/DRUG USE None Rarely Drink Social Drinker ___drinks/week Other

History of Alcoholism/Illicit Substance Use Current Past Sobriety for ___ years

MARIJUANA USE Current Medica/ Recreational Past Medical/Recreational

MARTIAL STATUS Single Married Widowed Other Number of Children _____

HIGHEST EDUCATIONAL LEVEL Grade _____ GED HS Years of College _____
AA BA BS Other ____________

ARE YOU IN SCHOOL NOW? NO YES Full-Time Part-Time

OCCUPATION / JOB TITLE ____

CURRENT EMPLOYER ____

HOW LONG WITH CURRENT EMPLOYER (years or start date) _____________

My Last Day at Work was ____ Today
Month Day Year

NOT CURRENTLY EMPLOYED LAID-OFF RETIRED SOCIAL SECURITY DISABILITY

MILITARY SERVICE NONE Navy Army Marine Corps Air Force Reserve
Years of Service _____ Year Discharged _____ Honorable Discharge? Yes Other

HEIGHT _____ ft _____in WEIGHT _________ pounds

FR EM HG LA FILE 8___ ___ ___

I, ______________________________________(print name) agree to the following:

The information supplied to Dr. Parkerson is true and complete to my best knowledge.

I consent to Dr. Parkerson's review of my medical records and his clinical examination. Medical records and bills generated from this evaluation will be sent to the referral source (for example the insurance company, my attorney, or my employer). Requests for a copy of Dr. Parkerson's report must first be directed to the referral source.

If the insurance company or my employer has referred me for examination, I am not responsible for Dr. Parkerson's charges. If I have been referred for examination by my attorney or myself, I remain fully responsible to pay Dr. Parkerson's fee and any reasonable collection costs that he incurs regardless of insurance coverage or outcome of any litigation.

I understand that if my examination is for the purpose of an independent medical evaluation. Dr. Parkerson will not become my treating physician or give me medical advice regarding prognosis or recommendations for further care. No treating doctor-patient relationship is established with this examination.

I authorize Dr. Parkerson to release any medical information necessary to process my claim.

SIGNATURE ____

__________________2025
DATE

WITNESS ____

__________________2025
DATE