PAST MEDICAL HISTORY:

Have you ever had or do you now have any of the problems listed below (please circle if *YES*):

Anemia	Epilepsy	Migraine/Headaches	Mononucleosis	Heart Disease	Gout
Stroke	Hernia	Bleeding Disorder	Eye Disease	Depression	Asthma
Phlebitis	High Blood Pressure	Tuberculosis	Hemorrhoids	Sickle Cell	GERD
Arthritis	Gall Bladder Disease	Cancer/Tumors	Diabetes	Pneumonia	Degenerative Disc
Kidney Stones	Thyroid Disease	Emphysema	Hypoglycemia	Sinusitis	Seizures
Urinary Tract Inf.	Bowel Problems/Colitis	Fractures (list below)	Hepatitis/Jaundice	Bronchitis	Sleep Apnea

Other:_____

_____

_____

PRIOR SURGERIES/STUDIES:

Procedure Date

1. _____
2. _____
3. _____
4. _____
5. _____

Imaging (MRI, CT, x-rays)

Body Area Hospital System/Location Site Approximate Date

1. _____
2. _____
3. _____
4. _____
5. _____

ALLERGIES:

Do you have allergies to medications? Yes No Allergy to Contrast for Imaging? Yes No

If yes, please list each medication and each allergic reaction:

_____

_____

Do you have environmental or food allergies? Yes No

If yes, please list: _____

List all the medications (prescription and non-prescription) that you take now. Put a star next to the ones that you are taking for pain management:

NAME OF MEDICATION	DOSAGE	HOW LONG have you taken this?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(use blank paper if more room needed)

Name: _____ Date of Birth: _____