

PATIENT HISTORY FORM

PATIENT NAME: _____

Age: _____ Height: _____ Weight: _____

What symptoms brought you to the center? _____

How/when did this first occur? _____

Were you injured? ___ Yes ___ No When & How? _____

Doctor's name that referred you here: _____

List types and dates of all surgeries: _____

If Back surgeries, what level? _____

Related to today's visit, have you had any of the following? ___ CT ___ MRI

___ X-RAY ___ Ultrasound

When? _____

Where? _____

Results? _____

Hip/Leg pain or numbness: ___ YES ___ NO ___ RIGHT ___ LEFT

Neck/Arm/Hand pain or numbness: ___ YES ___ NO ___ RIGHT ___ LEFT

Medical History:

Liver Disease ___ YES ___ NO

Hepatitis ___ YES ___ NO

Sickle Cell ___ YES ___ NO

Kidney Disease ___ YES ___ NO

Glaucoma ___ YES ___ NO

HIV Positive ___ YES ___ NO

Hypertension ___ YES ___ NO

Heart Disease/Stroke ___ YES ___ NO

Diabetes ___ YES ___ NO

Seizures ___ YES ___ NO

Hx of Cancer ___ YES ___ NO

If yes, specify type: _____

Treatment type for cancer? _____

IV enhancement/Iodine allergy: ___ YES ___ NO If yes, explain reaction: _____

Any known allergies: ___ YES ___ NO List all known allergies: _____

List all medications you are on at the present: _____

List any medications you have taken today: _____

Female Patients: Is there any possibility that you are pregnant? ___ YES ___ NO

Date of last menstrual period: _____