PATIENT HISTORY FORM

PATIENT NAME: _____ DOB: _____
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: _____