

**Patient Medical History**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

IF YOU ANSWER YES TO ANY QUESTION BELOW PLEASE EXPLAIN BRIEFLY

Heart Problems NO YES \_\_\_\_\_

Lung Problems NO YES \_\_\_\_\_

Kidney Problems NO YES \_\_\_\_\_

Liver Problems NO YES \_\_\_\_\_

Have you ever smoked? NO YES (If yes, how long?) \_\_\_\_\_

Do you have allergies? NO YES \_\_\_\_\_

Do you have diabetes? NO YES (If yes, what medication do you take?) \_\_\_\_\_

Do you have asthma? NO YES \_\_\_\_\_

Do you have any Neurologic condition? NO YES \_\_\_\_\_

Have you ever had surgery? : NO YES \_\_\_\_\_

Have you ever had an MRI? NO YES \_\_\_\_\_

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**FOR STAFF USE ONLY**

**NOTES:**

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