PATIENT HISTORY

Today's Date: ____________________

PATIENT NAME: ______________________________

Date of Birth: __________________ Height: ___________ Weight: __________

What is the reason for your visit today?

____

____

____

Any Allergies (including medications)? Yes No

If yes, please list: ____

____

Are you allergic to IV contrast used in radiology? Yes No

Do you take medication? Yes No

If yes, please indicate dosage and how often (include herbal medicines): ____________________

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____

Please list all past and present medical conditions: ____________________________________

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____

Do you have problems with anesthesia? Yes No

Have you had any surgeries? Yes No

List all surgeries and dates performed: ____

____

____

Any bleeding or clotting disorders? Yes No

If yes, please list: ____

Do you use alcohol? Yes No If so, how often? ______ day/week

Do you smoke? Yes No If so, how much? ______ day

Family Medical History (Please list medical illnesses of all family members)

Relationship	Age	Condition	If deceased, what age