



NAME:)B:	TODAY'S DATE:				
PAST MEDICAL HIST	ORY:							
□ Yes □ No - Hypertensi	ion □ Yes □ No - A	Asthma □ Y	es □ No - H	istory of bloo	d clot/embolus	□ Yes □ l	No - Sleep ap	nea
□ Yes □ No - Heart prob				-	disorder		No - Osteopo	
□ Yes □ No - Heart attac	k □ Yes □ No - S	leizures 🗆 Y	es □ No - D	iabetes	A1C	□ Yes □	No - Skin inf	ections
□ Yes □ No - Stroke	□ Yes □ No - C	Cancer \square	Yes □ No - K	idney disease	□ Yes □	□ No - MRS	A/surgical in:	fection
SOCIAL HISTORY:			FAMILY I	HISTORY:				
			(Please list	diseases for i	mmediate fami	ly only)		
Important Hobbies								
□ Married □ Widowed	~					~~~		
Smokes □CurrentlyPa Alcohol □ No □ Yes	•	□Never		ISTORY OF I	BLOOD CLOTS	S/BLEEDING	G DISORDER	is:
CURRENT MEDICAT	IONS:							
BLOOD THINNERS: _								
ALLERGIES: \square Yes \square	No - LATEX	Yes □ No - M	ETAL 🗆	Yes 🗆 No - 1	NICKEL	□ Yes □ No	- JEWELR	Y
MEDICATION ALLER	RGIES:							
SURGERIES:								
REVIEW OF SYSTEM	S: (Please circle all th	at apply)						
GENERAL	None / Recent weigh	nt change / Ch	ills / Fever / '	Weakness / Fa	atigue Other:			
EYES	None / Eyes / Vision Changes / Glasses-Contacts / Cataracts/ Glaucoma Other:							
EARS/NOSE/THROAT	None / Hearing loss	/ Ear ache-Inf	fection / Ring	ing in ear / He	oarseness Othe	er:		
CARDIOVASCULAR	None / Chest pain / Swelling in legs / Shortness of breath / Palpitations / Pacemaker-Defibrillator / Stent /							
	Open heart surgery	Other:						
RESPIRATORY	None / Shortness of breath / Wheezing-Asthma / Frequent Cough Other:							
${\tt GASTROINTESTINAL}$	None / Heartburn / Acid Reflux / Nausea/Vomiting / Abdominal pain Other:							
MUSCULOSKELETAL	None / Arthritis-Joint stiffness / Muscle aches / Swelling of joints Other:							
SKIN	None / Rash / Ulcers / Abnormal scars / Sores Other:							
NEUROLOGICAL	None / Headaches / Fainting-blackouts / Numbness, tingling, loss of sensation Other:							
PSYCHIATRIC	None / Depression / Nervousness-anxiety / Mood Swings Other:							
ENDOCRINE	None / Excessive thirst or hunger / Hot-Cold intolerance / Hot Flashes / Insulin Pump Other:							
HEMATOLOGICAL	None / Easy bruising	g / Easy bleed	ing / Anemia	/ Pacemaker-	Defibrillator O	ther:		
MISCELLANEOUS:								
Are you pregnant?	YesNo)	Ar	e you claustre	ophobic?	Yes	_No	
Do you have any metal in	your body from prev	ious surgery o	or do you wea	r any patches	that have meta	l on them? _	Yes	No
PERSON COMPLETIN	NG FORM							
Patient signature:				Date:				
DATE	NURSE	PATIENT	DOCTOR	WEIGHT	HEIGHT	BMI	B/P	
								1
								1
				-				1