PATIENT NAME_________________________ DR. SIGNATURE_________________

WHAT ARE YOU BEING SEEN FOR TODAY? ________________________________

CURRENT MEDICATIONS: ____

____

ARE YOU ALLERGIC TO ANYTHING? _______________________________________

LIST ANY OPERATIONS YOU HAVE HAD ____________________________________

PLEASE CHECK ANY THAT APPLY

DIABETES____
HEART DISEASE____
ASTHMA___
STOMACH PROBLEMS____
FAINTING SPELLS_____
DOUBLE VISION_____
STROKE____
SPEECH DIFFICULTY____
THINKING DIFFICULTY_____
HEADACHES_____
HEAD INJURY_____
BACK INJURY_____
NECK INJURY_____
EMOTIONAL PROBLEMS_____
DIZZINESS/VERTIGO_____
PACEMAKER______

HIGH BLOOD PRESSURE____
LUNG/BREATHING PROBLEMS___
THYROID PROBLEMS____
SEIZURES_____
BLACKOUT SPELLS_____
LOSS OF VISION______
WEAKNESS IN:
FACE____
ARMS____
LEGS_____
NUMBNESS IN:
FACE_____
ARMS_____
LEGS _____
HIGH CHOLESTROL______

ADDITIONAL INFORMATION ____

HAVE YOU BEEN INVOLVED IN A MVA? _______________DATE: ______________

DO YOU SMOKE? ___________PACKS PER DAY ___________HOW LONG? ______

DO YOU DRINK ALCOHOL? ____________ DRINKS PER WEEK? _____________

WEIGHT? _______ HEIGHT ____________________

FAMILY MEDICAL HISTORY ____

COULD YOU BE PREGNANT? ____

ARE YOU CLAUSTROPHOBIC? ___________________