

# PATIENT MEDICAL HISTORY

Please fill out completely.

Your **NAME** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Date** \_\_\_\_\_

Your **FAMILY DOCTOR** \_\_\_\_\_

Please circle correct answers and fill-in all blanks when applicable.

Do you have any **ALLERGIES** to Medications? **Y** **N** If Yes Please List Below

Do you have any **MEDICAL PROBLEMS?** **Y** **N** Please circle any that apply

Diabetes High Blood Pressure Heart Disease Lung Disease Stomach Problems / Ulcers

A Pacemaker Asthma Bleeding Problems Thyroid Disease Cancer Kidney Problems

Seizures Rheumatoid Arthritis Osteoporosis Fibromyalgia Liver Disease

Other: \_\_\_\_\_

Does anyone in your **FAMILY** have any significant **MEDICAL PROBLEMS?** **Y** **N**

If Yes please describe: \_\_\_\_\_

List your **Current Medications:**

**Prior Surgeries:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had **RECENT ILLNESSES** or medical problems? **Y** **N**

If Yes Please describe: \_\_\_\_\_

Are you **CLAUSTROPHOBIC?** **Y** **N**

Do you have any **METAL FRAGMENTS** in your body or eyes? **Y** **N**

Have you had **METAL** removed from your body or eyes? **Y** **N**

Do you work with **METAL, WELDING** or **GRINDING?** **Y** **N**

Your **Height** \_\_\_\_\_ Your **Weight** \_\_\_\_\_

Do you **SMOKE?** **Y** **N** If Yes, How Much? \_\_\_\_\_

Do you Drink **ALCOHOL?** **NEVER** **EVERYDAY** **OCCASIONALLY**

If **FEMALE**, Are you **PREGNANT?** **Y** **N** **MAYBE**

If **YES** or **MAYBE**, please notify your **Doctor**.