

Medical History Form

Name _____ Age _____ Date/Place of Birth _____

Occupation _____ Spouse's occupation _____

Hobbies _____

Past Medical History

Please circle any of the following illnesses which you have had in the past.

Angina	Stomach ulcer	Asthma
High blood pressure	Gallbladder disease	Tuberculosis
Heart attack	Colon Disease - type _____	Gout
Heart murmur	Diabetes mellitus	Rheumatoid arthritis
Vascular disease	Thyroid disease	Osteoarthritis
Cancer - type _____	Kidney disease	Lupus
Stroke	Anemia	Bleeding disorder
Seizure disorder	Spinal abnormalities	Headaches
Multiple Sclerosis	Ruptured disc	Hepatitis-type _____
Eye disease -type _____	Pinched nerve	Muscle disease
OTHER _____		

Are you claustrophobic? _____ Yes _____ No

Please list all previous hospitalizations:

Diagnosis	Hospital	Date	Doctor
-----------	----------	------	--------

List all medications you are currently taking:

List all medication allergies: _____

FAMILY HISTORY

Seizures _____

Neurological diseases _____

Stroke or heart attack in family less than age 50 _____

Other hereditary diseases _____

SOCIAL HISTORY

Marital status (Please circle) Single Married Divorced Widowed

Do you drink alcoholic beverages? YES NO

If yes, what type and on an average, how much per week

Smoking habits: YES NO

What do you smoke and how much? Past _____ Now _____