REASON FOR PROCEDURE:

Please check any of the following symptoms that you are experiencing relating to today's exam:

☐ Chest Pain	☐ Headaches	☐ Nausea	☐ Hearing Loss
☐ Abdominal Pain	☐ Blackouts	☐ Blurred Vision	☐ Ringing in Ears
☐ Pelvic Pain	☐ Dizziness	☐ Memory Loss	☐ Seizures
☐ Back Pain	☐ Unexpected weight loss		

Shoulder pain?	☐ Right	☐ Left	Numbness?	☐ Right ☐ Left
Leg Pain?	☐ Right	☐ Left	Weakness?	☐ Right ☐ Left
Arm Pain?	☐ Right	☐ Left	Other?	

How and when did these symptoms occur?

_____

_____

_____

MEDICAL HISTORY:

Please check any of the following medical problems you may have or had in the past:

☐ Cancer	☐ Kidney/Renal Disease	☐ Seizures
☐ Sickle Cell	☐ Heart Disease	☐ Stroke
☐ Congenital Heart Defect	☐ Bleeding Tendency	☐ Hypertension
☐ Asthma, Bronchitis or Emphysema	☐ Multiple Myeloma	☐ Diabetes
☐ Heart Arrhythmia	☐ Other Illness/Disease	☐ Tumor, Lump or Mass

Have you had any test? (MRI, CT, X-RAY, etc.) performed for the symptoms you are currently experiencing? If **yes,** please list the date, type and where the test was performed.

_____

Have you had surgeries or therapies? (Surgery, Radiation Therapy, Chemotherapy, etc.) If **yes,** please list the date and type of surgery or therapy)

_____

I hereby certify that the above information is true and correct to the best of my knowledge.

_____ Signature