Patient History Intake Form

Date:______________Patient Name_____________________________________

Reason for today's visit____

Drug Allergies? ___ Yes ___No

If yes please list: ____________________________ ___________________________

____________________________ _ ___________________________

List current Medications: ______________________ ___________________________

______________________ ___________________________

________________________ ___________________________

Surgeries? ____Yes ____No

If yes please list: ___________________________ ___________________________

___________________________ ___________________________

___________________________ ___________________________

Any Reaction to IV Contrast? ____Yes _____No _____N/A

Pacemaker or Defibrillator? ____Yes _____No **Heart Stents?** ____ Yes _____No

Do you smoke or have a history of smoking? **___**Yes ___No

Are you on a daily Aspirin regimen? _____Yes ____No

Your Current Pharmacy Name & Location:

____

Please indicate if there is a family history of the following:

____Bladder Cancer

____Breast Cancer

____Prostate Cancer

____Testicular Cancer

____Renal (kidney) Cancer