PATIENT ADMISSION SHEET

PAST MEDICAL HISTORY				
Are you allergic to anything? (please list specific allergies)				
	YES	**NO**	**FAMILY HISTORY**	**COMMENTS**
Lung Disease or Respiratory problems (emphysema, bronchitis, etc.)				
Tuberculosis				
Persistent cough or cough that produces blood				
Liver Disease				
Cardiovascular disease (heart trouble, heart attack, pacemaker)				
Do you have high blood pressure?				
Angina				
Stroke				
Sinus trouble				
Fainting spells				
Recent weight loss				
Diabetes				
Hepatitis, jaundice or liver disease				
Thyroid problems				
Arthritis or painful swollen joints				
Stomach ulcer or esophageal reflux				
Kidney trouble				
Have you had abnormal bleeding?				
Have you ever required a blood transfusion?				
Do you have a blood disorder such as anemia?				
Are you claustrophobic, a metal worker or have implants?				
Are you pregnant?				
Are you taking birth control pills?				
Any history of epilepsy (seizure disorder)?				
Any history of Cancer?				
Have you ever been treated for mental Illness?				
Are there any other medical problems that you are currently being treated for?				
Do you drink alcohol?	How often?			
Do you smoke?	How often?			

Please list any prior surgeries:				

Please list your current medications: ** We will be happy to copy a medication list if you have one.**

Medication name	**Daily Do**	**How ofte**	**Reason for taking**