Imaging Studies:

Date	MRI / CT / X-Ray	Body Part	Facility
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you Claustrophobic? _____

Laboratory Testing:

Date	Type of Test	Facility
_____	_____	_____

Surgeries:

Date	Type of Surgery	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication List: Pharmacy Name: _____ Phone: _____

Medication	Dosage	Prescriber
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: _____ _____ _____

Patient Name: _____