Have you had any of the following? Please list when, where, and referring doctor.

Nerve Blocks/Epidurals: _____
Physical Therapy: _____
Surgery: _____
X-Ray: _____
CAT Scan: _____
MRI: _____
EMG/NCV: _____

Do you currently have or have you ever had problems in any of the following areas.

Heart: _____
Lungs: _____
Kidneys: _____
Liver: _____
Neurological: _____
Others: _____

What is your past surgical history? _____
_____
_____

Please list all medications you are currently taking, prescription and non-prescription.

Medication	**Dose**	**How Often**	**Prescribing Doctor**	**Does it help?**
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____

Please list your allergies and allergic reactions:

_____
_____

Do you drink alcohol? _____ How often and how much? _____

Do you smoke? _____ How much per day? _____ How many years? _____

Please list the name, specialty, and phone numbers of doctors you have seen regarding your pain.

_____
_____
_____

Thank you.