PATIENT NAME:_____

DATE:_____D.O.B._____

CT Advanced Spine, LLC.
ASHISH UPADHYAY, MD

PATIENT MEDICAL HISTORY **Circle ALL that apply**
Respiratory: Asthma COPD Tuberculosis
Cardiac: High blood pressure Congestive heart failure Heart attack Pacemaker Atrial fibrillation Angina
Gastrointestinal: Hepatitis A/B/C Cirrhosis Other liver disease Stomach ulcer Gastroesophageal reflux disease (GERD)
Renal/Genitourinary: Renal Failure Kidney stones
Endocrine: Diabetes Hypothyroidism Hyperthyroidism High cholesterol
Neurological: Stroke TIA Dementia Alzheimers Neuropathy Epilepsy/Seizures
Musculoskeletal: Arthritis Osteoporosis Rheumatoid Arthritis
Psych: Depression Anxiety Bipolar
Hematology: Anemia Blood clot/DVT HIV Abnormal bleeding
General Medical: Recent weight loss- from diet or unexplained?
Cancer: *If history of cancer, what type:*

1. Family history of brain or spinal cord/bone tumor? Yes No
If yes, what type and where?_____

2. Are you claustrophobic? Yes No

3. Are you pregnant? Yes No

4. Have you worked with metal or have implants?
Yes No If yes, where?_____

5. Smoking status:
NEVER?
CURRENT? How much? _____
How long? _____
Former? Quit day? _____
How long?_____

7. Do you drink alcohol? Yes No
If yes, circle the correct choice:

- Less than 2 drinks per day
- 2-3 drinks per day
- more than 4 drinks a day

SURGICAL HISTORY Please list ANY prior surgeries
PERTINENT PAST MEDICAL HISTORY

MEDICATIONS Please list all medications with dosage and frequency.

ALLERGIES Please list allergies, and include reaction

Allergies	Reactions