Comprehensive Pain
MANAGEMENT SPECIALISTS

PATIENT REGISTRATION

Note: This form may be completed manually or on your computer. To complete this form on your computer: 1. Type your answer in each field. 2. Save your work often on your computer or device. 3. Print the completed form and bring it with you to your first appointment.

How did you hear about us?
- ☐ Newspaper
- ☐ Social media/Web search
- ☐ Insurance referral
- ☐ Family/Friend

PATIENT INFORMATION

NAME (Last, First, M.I.)	SSN	BIRTHDATE	LANGUAGE	PRIMARY CARE PROVIDER	SEX ○ M ○ F
BILLING ADDRESS	APT #	CITY		STATE	ZIP
PHYSICAL ADDRESS (If different from billing address)	APT #	CITY		STATE	ZIP
CELL PHONE XXX-XXX-XXXX	HOME PHONE XXX-XXX-XXXX	DAY PHONE XXX-XXX-XXXX	EMAIL ADDRESS (EXAMPLE@TEST.COM)		
PREFERRED CONTACT METHOD (REQUIRED) ○ CELL ○ HOME ○ DAY ○ EMAIL	MARITAL STATUS	MOTHER'S MAIDEN NAME	RACE	ETHNICITY	
EMERGENCY CONTACT NAME	PHONE NUMBER XXX-XXX-XXXX				

PRIMARY EMPLOYER		SECONDARY EMPLOYER (If applicable)	
ADDRESS	SUITE #	ADDRESS	SUITE #
CITY, STATE, ZIP		CITY, STATE, ZIP	
WORK PHONE XXX-XXX-XXXX	OCCUPATION	WORK PHONE XXX-XXX-XXXX	OCCUPATION

POLICYHOLDER/GUARANTOR (If different than patient)

NAME (Last, First, M.I.)	SSN	BIRTHDATE	LANGUAGE	PRIMARY CARE PROVIDER	SEX ○ M ○ F
BILLING ADDRESS	APT#	CITY		STATE	ZIP
PHYSICAL ADDRESS (If different from billing address)	APT#	CITY		STATE	ZIP
CELL PHONE XXX-XXX-XXXX	HOME PHONE XXX-XXX-XXXX	DAY PHONE XXX-XXX-XXXX	EMAIL ADDRESS (EXAMPLE@TEST.COM)		
PREFERRED CONTACT METHOD (REQUIRED) ○ CELL ○ HOME ○ DAY ○ EMAIL	MARITAL STATUS	MOTHER'S MAIDEN NAME	RACE	ETHNICITY	
RELATIONSHIP TO PATIENT					

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY			POLICY #	
NAME OF POLICY HOLDER		DOB	GROUP #	
RELATIONSHIP TO PATIENT			COPAY AMT $	
ADDRESS OF INSURANCE COMPANY		SUITE #	DEDUCTIBLE AMT $	
CITY, STATE, ZIP	PHONE XXX-XXX-XXXX		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY			POLICY #	
NAME OF POLICY HOLDER		DOB	GROUP #	
RELATIONSHIP TO PATIENT			COPAY AMT $	
ADDRESS OF INSURANCE COMPANY		SUITE #	DEDUCTIBLE AMT $	
CITY, STATE, ZIP	PHONE XXX-XXX-XXXX		EFFECTIVE DATE	EXPIRATION DATE

FINANCIAL POLICY: Payment in full or co-payment is expected at the time of service. Services provided that are not a covered benefit of your health plan will be your responsibility.

CONSENT TO TREATMENT/RELEASE OF INFORMATION: I grant Comprehensive Pain Management Specialists to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the insurer's agents to process my payments for service. To the best of my knowledge, all of the information above is true and correct. **ASSIGNMENT OF BENEFITS:** I thereby assign all benefits payable by my insurance company to Comprehensive Pain Management Specialists.

PATIENT/GUARDIAN SIGNATURE ______________________ ______________ ______________________

DATE RELATIONSHIP TO PATIENT

COMPREHENSIVE PAIN
MANAGEMENT SPECIALISTS

PATIENT FINANCIAL AGREEMENT

- **Co-Payments:** Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit.
- **Deductible Payments:** If your insurance requires you to meet a deductible before services are covered, payment must be made at the time of service. A $100.00 payment will be due at the time of service. Please note the $100.00 payment does not constitute payment in full and any additional balance must be paid upon receiving notification from our practice.
- **Claims Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Payment from your insurance company is expected within 45 days. After 45 days, we will look to you for payment in full. You will be responsible for all non-covered services according to Medicare guidelines. We must have a copy of your most recent cards and any secondary insurance or supplement you may have. Accounts that are 90 days past due are subject to being sent to a collection agency or small claims court for the unpaid bills. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.
- **Preventive Care Services:** Routine exams are not always covered by your insurance. Please be aware that if an additional problem is addressed at the time of your visit, a co-pay, deductible or office visit fee may be charged. If services are denied for payment by your insurance or you have failed to provide us with your correct insurance information, you will be responsible to pay for these services.
- **Cash Pay Patients:** The amount you pay for today's scheduled office visit may not be your final payment. Other costs that may be accrued for today's appointment are including, but not limited to, laboratory tests, x-ray tests, any injections, special procedures or additional office visit charges.
- **Laboratory Bills:** Any laboratory procedures that are ordered during today's visit will be billed to you directly by the laboratory. Please contact your laboratory directly for any questions regarding your lab bill.
- **Missed Appointments:** Please note a $25.00 cancellation fee will apply for missed appointments or failure to cancel within 24 hours prior to your scheduled appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
- If at any time you should experience financial hardship and need to make special payment plan arrangements, please contact our billing office.

Assignment of Benefits: Authorization is hereby granted to release information as may be necessary to process and complete my insurance claim, and payment of medical benefit is to be paid directly to Comprehensive Pain Management Specialists for all services rendered. *Initials:* __________

I have read and understand the above statements. I agree to comply with the financial policies of the office and I am financially responsible for my account.

Patient or Guardian Signature: ______________________________ *Date:* ______________

Patient Name (please print) ______________________________ *Date of Birth:* ______________

COMPREHENSIVE PAIN
MANAGEMENT SPECIALISTS

PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION WITH OTHERS

I hereby grant permission to Comprehensive Pain Management Specialists to speak to the following individuals about my health and disclose my health information including billing and insurance. I understand this authorization does not include information regarding HIV, psychiatric, drug and/or alcohol records, which must be authorized on a separate release.

	NAME	DOB
Spouse	______________________	____________
Children	______________________	____________
	______________________	____________
	______________________	____________
Guardian	______________________	____________
Caregiver	______________________	____________
Sister	______________________	____________
Brother	______________________	____________
Friend	______________________	____________
Emergency Contact	______________________	____________
Other	______________________	____________

You may discuss my (please check all that apply)

☐ Visit Notes ☐ Laboratory Results ☐ X-rays ☐ Reports ☐ All Services and Treatment Rendered

I understand that I may revoke this authorization at any time in writing.

Patient Name (please print)______________________ Patient Date of Birth____________

Patient/Guardian Signature__________________________ Date____________

COMPREHENSIVE PAIN
MANAGEMENT SPECIALISTS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

COMPREHENSIVE PAIN MANAGEMENT SPECIALISTS

I hereby acknowledge that I have been offered a copy of Comprehensive Pain Management's Notice of Privacy Practices. I have been advised that a copy of the current notice will be posted in the reception area, and that any amended Notice of Privacy Practices will be available at each appointment.

______________________________ ______________________________
PATIENT NAME (please print) PATIENT DATE OF BIRTH

______________________________ ______________________________
PATIENT/GUARDIAN SIGNATURE DATE

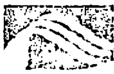
___-___-__________ ______________________________
PATIENT PHONE XXX-XXX-XXXX NAME OF PHYSICIAN

If not signed by the patient, please indicate relationship:

- ○ Parent or guardian of minor patient
- ○ Guardian or conservator of an incompetent patient
- ○ Beneficiary or personal representative of deceased patient

☐ I would like to receive a copy of any amended Notice of Privacy Practices via e-mail.

My email address is: ______________________________



LATEX ALLERGY QUESTIONNAIRE

COMPREHENSIVE PAIN
MANAGEMENT SPECIALISTS

Patient Name ______________________________ Date of Birth ______________

(5).... 1. Have you ever had an anaphylactic reaction to latex devises or products? .... ○ Yes ○ No

(1).... 2. Do you have spina bifida, myeloma, or myelodysplasia? .... ○ Yes ○ No

(*).... 3. Have you had a reaction to the following common sources of latex? .... ○ Yes ○ No

Check all that apply:

- ☐ Balloons
- ☐ Latex birth control devices
- ☐ Erasers
- ☐ Hot water bottles
- ☐ Foam pillows
- ☐ Pacifiers, teething rings
- ☐ Rubber gloves
- ☐ Dental cofferdams
- ☐ Face masks
- ☐ Rubber bands, balls
- ☐ Baby bottles, nipples
- ☐ Elastic bandages
- ☐ Belts, bras, suspenders
- ☐ Cuffs, elastic waistbands
- ☐ Rubber grips
- ☐ Ostomy bags
- ☐ Footwear

(4).... If you have checked any of the above in #3, have you experienced any of the following reactions? ..... ○ Yes ○ No

- ☐ Wheezing/shortness of breath
- ☐ Immediately on contact to the food (Urticaria, Hives)
- ☐ Chest tightness

(*).... "YES" answers to the following indicate potential for latex sensitivity:

- ☐ Runny nose / congestion
- ☐ Swelling
- ☐ Itching (e.g., hands, eyes)
- ☐ Chapping or "cracking" of the hands

(*).... 4. Do you have any allergies/sensitivities to the following foods? .... ○ Yes ○ No

Check all that apply:

- ☐ Avocados
- ☐ Bananas
- ☐ Potatoes
- ☐ Chestnuts
- ☐ Kiwis
- ☐ Peaches
- ☐ Papaya
- ☐ Tomatoes

(3).... If you have checked any of the above in #4, have you experienced any of the following reactions? ○ Yes ○ No

- ☐ Wheezing /shortness of breath
- ☐ Immediately on contact to the food (Urticaria, Hives)
- ☐ Chest tightness

(*).... "YES" answers to the following indicates potential for latex sensitivity:

- ☐ Runny nose / congestion
- ☐ Swelling
- ☐ Itching (e.g. hands, eyes)
- ☐ Chapping or "cracking" of the hands

(1).... 5. As an infant / child did you have multiple surgeries? .... ○ Yes ○ No

(1).... 6a. Are you a health care worker and have repeated exposure to products containing LATEX? .... ○ Yes ○ No

If yes, to which products do you have repeated exposure? ______________________

(1).... 6b. Does your job involve working in a factory where rubber or latex products are manufactured? ○ Yes ○ No

If yes, what products do you manufacture? ______________________

OFFICE USE ONLY

MAXIMUM SCORE POSSIBLE: 16-4 or below complete #1A & 1B

1. TOTAL SCORE ______________
   If 5 or ABOVE, complete # 2&3 and INITIATE LATEX PRECAUTIONS
   If 4 or BELOW and "YES" ANSWERS are marked for SENSITIVITY - questions 3&4

1a. PHYSICIAN(S) NOTIFIED Yes (Name of MD / Time) ______________ ☐ No

1b. Does Physician want to initiate LATEX PRECAUTIONS? ☐ Yes ☐ No
   If 5 or above continue the following questions

2. Identification of the patient and room ______________
   LATEX added to allergy computer screen? ☐ Yes - patient banded with "LATEX PRECAUTIONS" armband ☐ No
   LATEX PRECAUTIONS sticker ☐ Yes - on door ☐ Yes - on bed ☐ Yes - on wall ☐ Yes - on chart
   KARDEX marked with "LATEX PRECAUTIONS" ☐ Yes

3. Physician(s) Notified: Patient placed on "LATEX PRECAUTIONS" (Name of MD / Time) ______________

______________________ RN/ LVN/ RT/ OT/ MA

______________________ Date

COMPREHENSIVE PAIN
MANAGEMENT SPECIALISTS

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Phone: (858) 453-7700
Fax: (858) 798-1225

Patient Name	**Patient Date of Birth**

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

I hereby authorize the disclosing physician or health care provider noted below to release medical information to the receiving physician or health care provider indicated:

FROM:	______________________	**TO:**	Comprehensive Pain Management Specialists
	(Disclosing physician or provider)		***(Receiving physician or provider)***
	______________________		16466 Bernardo Center Dr, Suite 150
	(Street Address)		***(Street Address)***
	______________________		San Diego, CA 92128
	(City, State, Zip Code)		***(City, State, Zip Code)***

Release records and information regarding: ______________________
(Patient's Name)

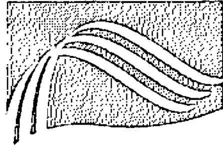
______________________ ______________________ ______________________
(Date of Birth) ***(Social Security #)*** ***(Telephone Number)***

____
(Address, City, State, Zip Code)

DURATION: This Authorization shall become effective immediately and shall remain in effect through ______________________ (enter date) or for one year from the date of signature if no date entered.

REVOCATION: This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the requestor may not lawfully further use or disclose the health information unless another Authorization is obtained from me or unless the disclosure is specifically required or permitted by law.

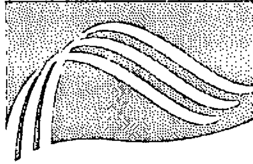


COMPREHENSIVE PAIN
MANAGEMENT SPECIALISTS

4510 Executive Drive, Suite 210, San Diego, CA 92121
16466 Bernardo Center Drive, Suite 150, San Diego, CA 92128
225E. Second Avenue, Suite 101, Escondido, CA 92025
Phone: 858.453.7700 Fax: 858.798.1225

CPMS Office Policies

- If you are more then **15** minutes late for your appointment you may be asked to reschedule your appointment.
- The office will need up to **72** hours to process all medication refill requests. It is your responsibility to plan accordingly. Any prescription refill that will need to be written on a triplicate will need an appointment for an evaluation.
- Medical record requests must be made in writing and can take up to **14** days to complete. We can provide you with the forms necessary to make your medical records request or you may find them on our website at **www.sdcpms.com**.
- All procedure appointments require that you have a driver (Exceptions: Trigger Point Injections and Occipital Nerve Blocks) when taking Valium. Please plan accordingly.
- Your co-payment or payment is required at the time you check in for your appointment. If you fail to bring your co-payment or payment we will need to reschedule your appointment.
- You will be assessed a "*Missed Appointment*" fee of **$25.00** for all appointment that you miss and fail to give at least **24** hours notice. As a courtesy you will receive a 48 hour reminder phone call, but ultimately the responsibility of the appointment rests with you. Please note who you speak to when you call to cancel your appointment, including the date and time.
- It is CPMS's policy to not complete disability, unemployment or any other types of forms. Please see your referring provider for completion of such forms.
- **As a courtesy please turn off or silence your cell phones while in the office.**



COMPREHENSIVE PAIN
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RE-EVALUATION

1. Referring Physician: ______________________
2. Patient ID #__________
3. Your appointment is with ☐ Dr. Christopher Chisholm ☐ Dr. Timothy Chong

PATIENT INFORMATION

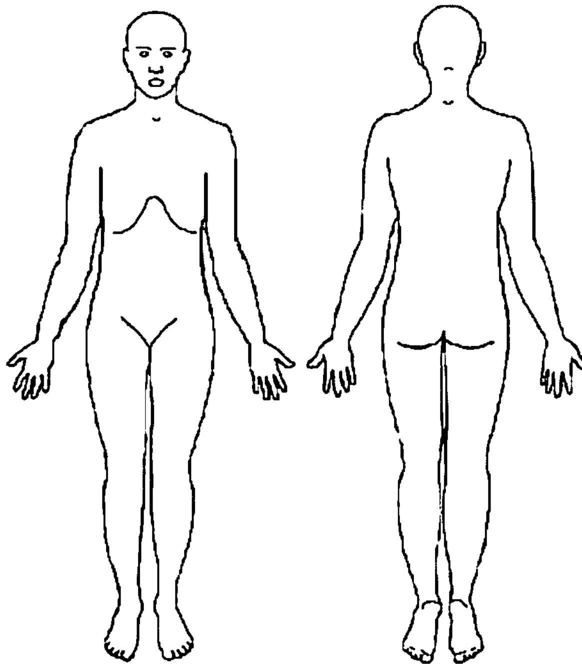
4. ______________ ______________ ____
   Last Name First M.I.
5. Sex: ☐Male ☐Female
6. Appointment Date__________
7. Date of Birth (mm/dd/yyyy): ________
8. Age _______
9. Primary Care Physician (if not the same): ______________

ABOUT YOUR PAIN

10. What is the main problem for which you are seeking treatment with Comprehensive Pain Management Specialists?

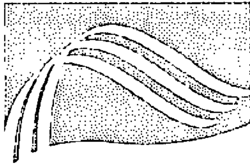
____
____
____

Please mark the area(s) in which your pain is located:



For office use only: C: C/PT: ______________ C/TDD: ______________

Patient Name: ______________________



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ONSET OF PAIN AND DURATION

11. Briefly describe when and how your current pain started?

____
____
____
____

TIMING OF PAIN

12. How often do you have your pain (please check one)?

- ☐ Constantly (100% of the time)
- ☐ Frequently (75% of the time)
- ☐ Intermittently (50% of the time)
- ☐ Occasionally (25% of the time)

PAIN QUALITY

13. How would you describe the pain (choose as many adjectives as are applicable)?

☐ Burning	☐ Sharp	☐ Cutting
☐ Throbbing	☐ Cramping	☐ Numbness
☐ Dull, aching	☐ Pressure	☐ Pins and needles
☐ Shooting	☐ Electric-like	☐ Other ___________

PAIN INTENSITY

14. Circle your current pain intensity with "0" representing no pain and "10" representing the most severe pain imaginable:

0 1 2 3 4 5 6 7 8 9 10

15. Circle your average pain the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

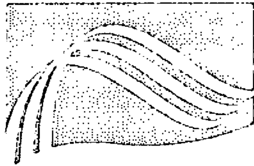
16. Circle your best pain score the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

17. Circle your worst pain score the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

Patient Name: ________________________________



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RELIEVING AND AGGRAVATING FACTORS

How do the following affect your pain (please check one for each item)?

	18 Decrease	19 Increase	20 No Change
Lying down			
Standing			
Sitting			
Walking			
Exercise (if applicable)			
Medications			
Relaxation			
Thinking about something else			
Coughing/Sneezing			
Urination			
Bowel movements			

PAIN TREATMENTS

Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right to the best of your ability.

☐ No change

Treatment	**Date (approx.)**	21 **Excellent Relief**	22 **Moderate Relief**	23 **No Relief**
Hospital bed rest				
Traction				
Surgery				
Hypnosis				
Acupuncture				
Nerve block/injections				
TENS				
Physical therapy				
Exercise				
Heat treatment				
Biofeedback				
Psychotherapy				
Chiropractic				
Other				

FUNCTIONAL LIMITATIONS

☐ No change

24. During the past month, place a check mark next to the activities that you avoided because of pain:

☐ Going to work
☐ Performing household chores
☐ Doing yard work or shopping
☐ Socializing with friends

Patient Name: ______________________________

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☐ Participating in recreation ☐ Having sexual relations
☐ Physically exercising ☐ Driving ☐ Caring for self

25. How many blocks can you walk before having to stop due to pain? __________
26. How many minutes or hours can you sit before having to get up and move about?
 _________ minutes _________ hours
27. How many minutes or hours can you stand before you have to sit down?
 _________ minutes _________ hours
28. How often during the day do you lie down because of pain?
 ☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Constantly

Allergies

☐ No change

29. Do you have symptoms like red itchy eyes, general itching, shortness of breath, wheezing, fast heartbeat, feeling faint, nausea, or vomiting when exposed to the following?

☐ Dye
☐ Iodine
☐ Medications: ____
 Describe: ____
☐ Shellfish
☐ Foods:
☐ **Latex**
☐ **Rubber (Band-aids, tape, spandex, balloons) ***
☐ **Kiwis, chestnuts, bananas, avocado ***
☐ **No Known Allergy**
☐ **After doctor/dental visits ***

MEDICATIONS

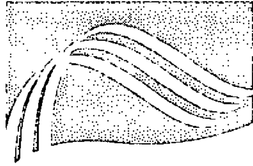
30. Please list your current medications with dosages:

____
____
____
____
____
____
____
____
____
____
____

31. Please list any previously taken pain medications that you stopped taking and the reason for stopping:

____
____

Patient Name: ____________________________________



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PAST MEDICAL HISTORY

32. Have you had any of the following health problems (please check all that apply)?

☐ High blood pressure ☐ Diabetes ☐ Kidney disease
☐ Angina ☐ Stroke ☐ Liver disease
☐ Heart attack ☐ Cancer ☐ Arthritis
☐ Chronic cough ☐ Psychological or psychiatric problems
☐ HIV ☐ Hepatitis

Please explain any medical conditions checked above:

☐ Other (please specify): ____________________

ALL PAST SURGERIES

33. Please list, with approximate date and type of operation:

Have you had any previous back surgeries (please specify)?

PSYCHOSOCIAL HISTORY

☐ No change

34. Your highest educational level achieved:
   - ☐ Graduate or professional training (obtained degree)
   - ☐ College graduate (obtained degree)
   - ☐ Partial college training
   - ☐ High school graduate
   - ☐ GED or trade-technical school graduate
   - ☐ Partial high school (10th grade through partial 12th)

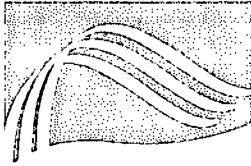
LEGAL ISSUES

35. Have you filed any legal claims related to your pain problem?
   ☐ No ☐ Yes (please explain): ____________________

PSYCHOLOGICAL TREATMENT

36. Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? ☐ Yes ☐ No
   If yes, when? ____________________
37. Have you ever considered suicide? ☐ Yes ☐ No

Patient Name: ____________________



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SUBSTANCE USE

38.Y 39. N

Are you suffering from or do you have a history or alcoholism? ☐ Yes ☐ No
Any illicit drug use? ☐ Yes ☐ No
Have you ever been in a detoxification program for drug abuse? ☐ Yes ☐ No
Alcoholics Anonymous? ☐ Yes ☐ No
Narcotics Anonymous? ☐ Yes ☐ No

40. Do you or did you ever smoke cigarettes or use tobacco? ☐ Yes ☐ No

How many years have you smoked/did you smoke? ____________
How many packs per day do you/did you smoke? ____________
Have you quit using tobacco, and if so how long ago? ____________

41. How many drinks of each of the following do you consume in one week?

Beer ____________
Wine ____________
Liquor ____________

FAMILY LIFE

42. "I currently am":

- ☐ Living alone
- ☐ Living with friends
- ☐ Living with children
- ☐ Living with spouse/partner
- ☐ Living with spouse/partner and children

43. N 44. Y

Do you have members of your family who have committed suicide?
☐ Yes ☐ No

Do you have members of your family who have had psychiatric illnesses?
☐ Yes ☐ No

Have any of your blood relatives had substance abuse problems, including alcohol?
☐ Yes ☐ No

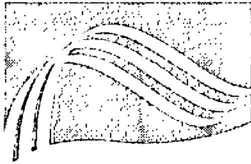
PREVIOUS DIAGNOSTIC STUDIES

☐ No change

45. Please indicate approximate date and results, if known:

MRI ____
CT ____
X-rays ____
EMG ____

Patient Name: ____



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REVIEW OF SYSTEMS

Fill out and/or check all that apply to your health:

Respiratory	Heart	Elimination	
		Urinary	Bowel
❑ Shortness of Breath ❑ at rest ❑ with activity ❑ Home oxygen (Supplier:________) ❑ Breathing medications ❑ BIPAP/CPAP ❑ Sleep Apnea Disorder ❑ TB ❑ Lung Problem:________ ❑ No Problem	❑ Bruising/Bleeding ❑ Heart Attack ❑ Palpitations ❑ Heart Problem: ________ ❑ Other:________ ❑ No Problem	❑ Catheter ❑ Burning ❑ Bleeding ❑ Ostomy ❑ Unusual Frequency ❑ Discomfort ❑ Up at night to urinate? # Times:________ ❑ Loss of control ❑ No Problem	Last BM________ Freq of BM________ ❑ Ostomy ❑ Loss of control ❑ Diarrhea/Colitis ❑ Constipation ❑ Use laxatives ❑ Ulcers/Hiatal Hernia ❑ No Problem

Neurological	Skeletal/Muscle	Nutrition
❑ Memory loss/ Forgetfulness ❑ Stroke ❑ Fainting spells/ Dizziness ❑ Epilepsy, seizures, convulsions ❑ Mental illness ❑ Headaches ❑ No problem	❑ Arthritis ❑ Numbness/Tingling ❑ Back pain ❑ Muscle weakness ❑ Blood clots in legs ❑ Pain in legs with activity ❑ Skin disorder ❑ Neck pain ❑ No problem	❑ Weight Loss > 10 lbs last 6 months ________ ❑ Nausea Appetite ❑ good ❑ fair ❑ poor ❑ Vomiting ❑ Dentures Fit properly? ❑ yes ❑ no ❑ Heartburn/Reflux ❑ Chewing problems ❑ Swallowing problems ❑ Indigestion ❑ No problems ❑ Sores in mouth ❑ Foods you CANNOT eat. Explain: ________ ________

Endocrine	
❑ Thyroid problems ❑ Other:________ ________ ❑ No problem	Do you have any implanted devices? ❑ Screws, pins, plates ❑ AICD ❑ Aneurysm Clip ❑ Venous Access Device ❑ None Where?________ ❑ IUD ❑ Pacemaker ❑ Type ________

Do you have a history of "passing out" with needles, medical procedures etc.? If yes, please explain.

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Positives 46. Negatives 47.

Patient Name: ________________________________