Revised 10/24/2011

Central California Neurology Medical Corporation
HEALTH QUESTIONNAIRE

Name (First M Last):_____

CIRCLE ONE

1.) Do you have any **drug** allergies? **YES** **NO**

Please List: _____

2.) Do you have any **other** allergies? **YES** **NO**

Please List: _____

3.) Do you have valley fever (hay fever) or asthma? **YES** **NO**

4.) Are you currently taking any medications? **YES** **NO**

Please List: _____

5.) Have you had any previous surgeries? **YES** **NO**

Please List: _____

6.) Do you have any known contagious diseases? **YES** **NO**

If so please list?: _____

7.) Habits: Do you smoke? **YES** **NO**

Number of packs per day?: _____ Number of years?: _____

8.) Do you use alcohol? Drinks per week?: _____ **YES** **NO**

9.) Do you have a pacemaker, stints, or any metal in your body? **YES** **NO**

If so please list?: _____

10.) Height:_____ Weight:_____lbs

11.) Are you claustrophobic? **YES** **NO**

12.) Check off the cause of your visit today: ( ) Car accident ( ) Work injury ( ) Sports injury ( ) Home

( ) Other:_____

Please provide any other health information you deem important:

X_____ _____

Signature of Patient or Personal Representative Date