

Outpatient Neuro/Musculoskeletal History Form

Procedure to be performed: (check one)

- Aspiration
 Cisternogram
 Epidural blood patch
 Lumbar puncture
 Lumbar drain
 Discogram*
 Epidural steroid injection*
 Myelogram*
 *Pain diagram below to be completed for: Discogram, Epidural steroid injection & Myelogram procedures

To be completed by the patient:

If this procedure is related to an injury, how did it occur? _____

If this procedure is related to pain, where is the pain located? _____

List any surgeries related to your area of pain _____

List allergies _____

Current medications _____

What is your current weight? _____ lbs

Check the appropriate box:

YES NO

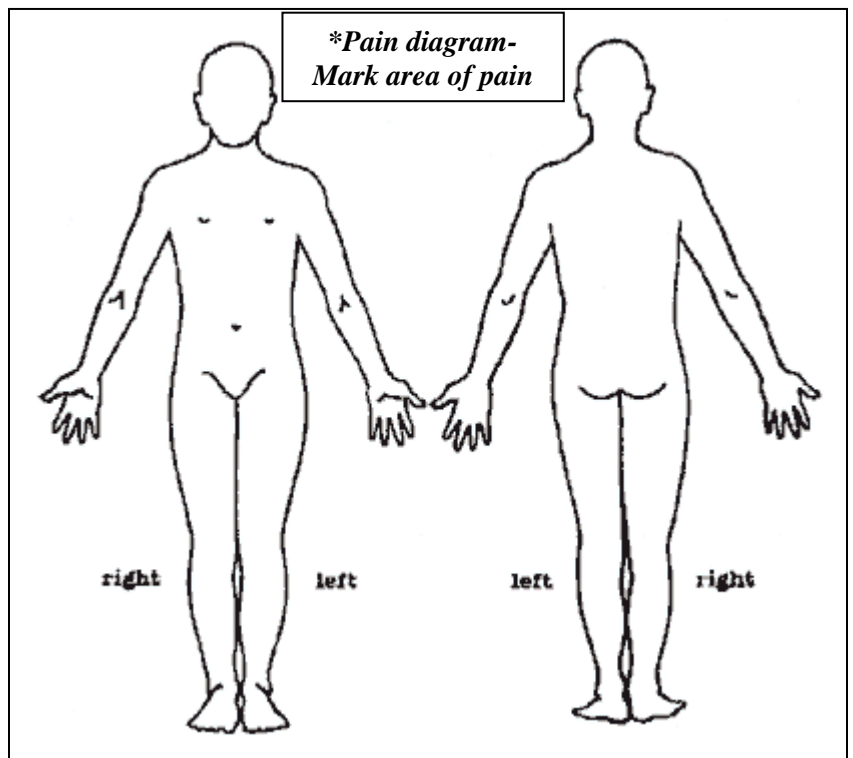
- Do you have a history of cancer? What type: _____
 Did you have Chemotherapy? Radiation? If yes, specify date of last treatment: _____
 Are you allergic to imaging contrast? If yes, date occurred? _____
 If yes to, describe the reaction _____
 If yes: Did you receive a medication to prevent a reaction?
 Tobacco use Frequency: _____
 Alcohol use Frequency: _____

Do you have any of the following:

- Heart disease or hypertension
 Lung disease
 Neurologic disorders, CVA or seizures
 Kidney disease
 Diabetes
 Colitis
 Hepatitis or bleeding problems
 HIV
 Snoring or sleep apnea
 Bleeding disorders

For female patients only:

- Are you pregnant or possibly pregnant
 If yes, how many weeks _____



 Patient/Authorized person signature Printed name Title (Self, Spouse, Nurse, etc) Date Time

 Qualified Staff / Interpreter Signature (Check) Phone OR Video Print Qualified Staff / Interpreter Name ID Number Language Interpreted

 Technologist Authentication OPID Date Time



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 040-1009 (6/19) MPC 206505

<i>Patient Label or</i>	
Patient Name _____	<input type="checkbox"/> Female <input type="checkbox"/> Male
DOB _____	MRN _____