

\*\*\* PLEASE PRINT \*\*\*

**MEDICATIONS**

CURRENT MEDICATIONS: What, if any, medications are you *currently* taking? Please list all current medications below (prescription and over the counter):

MEDICATION	WHY PRESCRIBED	DOSAGE	EFFECTIVENESS

Are you allergic to any medications?  No  Yes If yes, please list: \_\_\_\_\_

Are you taking any anticoagulants (blood thinners)?  No  Yes If yes, please list: \_\_\_\_\_

In the past 6 months to a year, which of the following tests have you had to evaluate your pain?

TEST	DATE	PLACE	RESULTS
<input type="checkbox"/> X-Ray			
<input type="checkbox"/> C-T Scan			
<input type="checkbox"/> MRI			
<input type="checkbox"/> Laboratory			
<input type="checkbox"/> EMG			
<input type="checkbox"/> Myelogram			
<input type="checkbox"/> Rectal / Hemoccult			