Curo clinic

PATIENT NAME_____M F EXAM DATE_____
TELEPHONE _____ TIME _____
WORK PHONE _____ EXAM_____
DOB _____ R/O _____
WEIGHT _____ PHYSICIAN_____

ALLERGIES_____

_____

Please check "yes" if you have any of the following:

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ___ | ___ | HISTORY OF LIVER DISEASE* | ___ | ___ | CLAUSTROPHOBIC |
| ___ | ___ | DIABETES* | ___ | ___ | HEARING AID, DENTURES |
| ___ | ___ | HISTORY OF KIDNEY DISEASE* | ___ | ___ | METAL IN EYES/GRINDING |
| ___ | ___ | HISTORY OF KIDNEY FAILURE* | ___ | ___ | PREGNANCY |
| ___ | ___ | ARE YOU ON DIALYSIS* | ___ | ___ | IMPLANTS OF ANY KIND |
| | | | ___ | ___ | ANEURYSM CLIPS |
| | | | ___ | ___ | NEUROSTIMULATOR |
| | | | ___ | ___ | PAIN PUMP(yes, schedule with Sally before 1 pm) |
| | | | ___ | ___ | COCHLEAR, STAPES IMPLANTS |
| | | | ___ | ___ | STENTS (IN HEART) |
| | | | ___ | ___ | PACEMAKER |
| | | | ___ | ___ | VAGUS NERVE STIMULATOR VNS |
| | | | ___ | ___ | SEIZURES |
| | | | ___ | ___ | HISTORY OF CANCER |
| | | | ___ | ___ | RADIATION OR CHEMO |
| | | | ___ | ___ | HYPERTENSION |

* IF YES, BLOOD CREATININE LEVEL MUST BE ORDERED
* LAB RESULTS ACCEPTABLE FOR 30 DAYS

Any Patient 60 or Older BUN & CR Required

**All above information is correct. ***PATIENT SIGNATURE** _____

EMPLOYEE SIGNATURE _____ Date _____

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