Ali Malek, MD

Interventional Neurology

Name: _____ **Date:** _____
Age: _____ **Height:** _____ **Weight:** _____

Is there any reason you would be unable to accept a **BLOOD TRANSFUSION**?
Yes/No. If yes, please describe. _____

FOR WOMEN ONLY: Are you pregnant? Yes/No Regular cycles? Yes/No
Date of last period: _____

FOR MEN ONLY: Any prostate problems? Yes/No. If yes, please describe. _____
_____

Have you had surgery in the past? Yes/No
Have you ever had any difficulty with anesthesia? Yes/No
If yes, for either, please describe. _____
_____
_____

Have you or your relative has **EXCESSIVE BLEEDING** during surgery? Yes/No
Have you had any of the following?

Measles	Yes/No	**Chicken Pox**	Yes/No
Diphtheria	Yes/No	**Tuberculosis**	Yes/No
Encephalitis	Yes/No	**Meningitis**	Yes/No
Emphysema	Yes/No	**Pneumonia**	Yes/No
Jaundice	Yes/No	**Hepatitis**	Yes/No
Arthritis	Yes/No	**Syphilis**	Yes/No
Anemia	Yes/No	**Epilepsy**	Yes/No
Rheumatic Fever	Yes/No	**High Blood Pressure**	Yes/No
Low Blood Pressure	Yes/No	**Heart Disease**	Yes/No
Urination Problems	Yes/No	**Thyroid Problems**	Yes/No
Kidney Stones	Yes/No	**Eye Problems**	Yes/No
Hearing Problems	Yes/No	**Headaches**	Yes/No
Concussion	Yes/No	**Weakness/Paralysis**	Yes/No
Numbness	Yes/No	**Dizziness**	Yes/No
Mumps	Yes/No	**Asthma**	Yes/No
Diabetes	Yes/No	**Polio**	Yes/No
Cancer	Yes/No	**Gonorrhea**	Yes/No
Ulcers	Yes/No		

Clinical Information (Other): _____

Ali Malek, MD

Interventional Neurology

Ct Scan/X-ray: Location and Date _____

MRI: _____ Location and Date: _____

Angiograms: _____ Location and Date: _____

Medical Information

Reason for your visit (Please summarize in 1-2 sentences): _____

_____

_____

Are you Left Handed ____ **Or Right handed** ____

Family History

Has any blood relative ever had?

Cancer	Yes/No	**Stroke**	Yes/No
High Blood Pressure	Yes/No	**Epilepsy**	Yes/No
Tuberculosis	Yes/No	**Psychiatric Disorder**	Yes/No
Diabetes	Yes/No	**Heart Problems**	Yes/No
Aneurysm	Yes/No		

Do you smoke? Yes/No **If yes, how many packs per day?** _____

Do you drink alcohol? Yes/No **If yes, how much and how often?** _____

Are you allergic to any medications? Yes/No **Which?** _____

Are you allergic to contrast dye? Yes/No

Are you allergic to any foods? Yes/No **Which?** _____

Do you have any METAL or IMPLANT? Yes/No

What is your approximate weight today _____ **Any recent weight loss?** Yes/No

What is your approximate height? _____

Please list all medications, including non-prescription drugs that you are taking:
