IMAGING SEDATION EVALUATION

PATIENT INTAKE FORM

Name:	
Address:	
City:	Zip code:
Phone: (home)	(Mobile) (Work)
Email:	Occupation:
Would you like to receive emails from South Florida Injury Convenient Care regarding your doctor's appointment? Yes ☐ No ☐	
Would you like to receive text messages from South Florida Injury Convenient Care regarding your doctor's appointment? Yes ☐ No ☐	
Sex *(circle one)*: M F	Date of birth:
Preferred Pharmacy:	Phone:
How did you discover our clinic? *(Circle one)*	Family Doctor | Radio | Friend/Family | Web | Facebook | Lawyer | Other *(specified)*: _____

REASON FOR CONSULTATION OR CONCERN: _____

MEDICAL HISTORY:

Do you have any of the following?

Diabetes?	Yes/No
Heart problems?	Yes/No
Epilepsy?	Yes/No
High Blood Pressure?	Yes/No
Circulation Problems?	Yes/No
Osteoporosis?	Yes/No
Bladder Problems?	Yes/No
HIV positive?	Yes/No
Have you had Cancer?	Yes/No
Have you experienced dizziness or fainting?	Yes/No
Sudden Weight Loss?	Yes/No
Breathing Problems?	Yes/No
Are you Pregnant?	Yes/No
Recent Surgery?	Yes/No
Arthritis?	Yes/No

Have you had problems with any sedatives before (example: Xanax/Valium**)?** _____

_____