Pain Care Consultants PC – Thomas W Hanlon MD
Patient Information

Patient Name: ____________________________ **Date:**______________________

DOB: ___________ **Age:**___________ **Social Security #**_____________________

Address: ___________________________**City State &Zip:**____________________

Phone: __________________________ **Email Address:** _______________________

Primary Care:_____________________ **Referring Physician**_________________

Pharmacy: ______________________________**Phone:**________________________

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

☐Heart disease / Murmur / Angina ☐Shortness of breathe ☐Diabetes

☐High cholesterol ☐Asthma ☐Seizures ☐Kidney / Bladder problems

☐High blood pressure ☐Lung problems / cough ☐Stroke ☐Liver problems / Hepatitis

☐Low blood pressure ☐Sinus problems ☐Headaches / Migraines ☐Arthritis

☐Heartburn (reflux) ☐Seasonal allergies ☐Neurological problems ☐Cancer

☐Anemia or blood problems ☐Tonsillitis ☐Depression / Anxiety ☐Ulcers/colitis

☐Psychiatric care ☐Thyroid problems

Drug Allergies: ____

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Are you on any Blood Thinner: ____

Please describe any current or past medical treatment not listed above

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Please list your past surgeries

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Allergies

Are you allergic to IV Contrast or Shellfish? ☐Yes ☐No

Medications

Please list:

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