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PLEASE PRINT CLEARLY

Name: _____ Age: _____ Weight: _____

Emergency contact person: _____ Phone No. (____) _____

Please list all allergies:

Food: (i.e. shellfish) _____

Medications: _____

X-ray Latex

Do you take or have you taken any Aspirin or Aspirin products (ex: Motrin, Advil, or Aleve), or any blood thinners (ex: Coumadin, Plavix) ? Yes No

If yes, please list: _____

When was the last date and time you took this? _____

	Current medications/ OTC/ Supplements	Dose/ Frequency	Last Dose Taken	Indications
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				
(11)				
(12)				
(13)				
(14)				
(15)				

Medical History: Pulmonary Disease Diabetes Mellitus Heart Disease
 Renal Disease Cancer Blood Disorder

History of the following surgeries: Neck Back Heart