1. Describe your problem and how long you have had it:

2. Is this a result of an injury?  ✔️ YES  ❌ NO  If yes, describe:

3. Have you had surgery for this problem?  ✔️ YES  ❌ NO  If yes, when and what type:

4. Please list all previous surgeries:

5. Have you had any other tests for this problem?  ✔️ YES  ❌ NO

6. If yes, please tell us what, when, where and the results:  ✔️ YES  ❌ NO

7. Do you have any history of cancer?  ✔️ YES  ❌ NO  If yes, where in your body:

8. Do you have any history of tumors?  ✔️ YES  ❌ NO  If yes, where in your body:

9. How has it been treated?  ✔️ Surgery  ❌ Radiation Therapy  ❌ Chemotherapy

If you are having a CT or MRI scan of your spine, please shade where your pain is in this drawing:

- Neck Pain
- Arm Pain
- Arm Numbness
- Arm Weak
- Leg Pain
- Leg Numbness
- Leg Weak
- Bladder Dysfunction

Partners Allergies Past History Record

- Are you allergic to Foods/Medication?  ✔️ YES  ❌ NO
- Do you have any history of High Blood Pressure or Heart Disease?  ✔️ YES  ❌ NO
- Do you have diabetes?  ✔️ YES  ❌ NO
- Do you have a history of kidney disease?  ✔️ YES  ❌ NO
- Are you diabetic?  ✔️ YES  ❌ NO
- Do you currently take the diabetes medication cetaximulin?  ✔️ YES  ❌ NO

If there is a chance you could be pregnant,  ✔️ YES  ❌ NO

I certify that the above information is correct to the best of my knowledge.

Patient's Signature

715-CTQ-201 (Rev 12.13) Contrast Questionnaire
Outpatient Medication Reconciliation Form

Patient Name ____________________________ Date/Time ______________________

(A) This form is for informational purposes only and NOT to be used as a Physician Order. It is NOT to be used for inpatient admissions.
(B) This is NOT a prescription. It is a list of your medications and new orders.
(C) If you have any questions regarding any medications listed on this form, or about any medications you may have been on before coming to the hospital, please call your Primary Physician.
(D) If your physician needs another copy of this list, please have him/her call Health Information Services at: 707-312-6114.

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<th>Medication Name</th>
<th>Time of last dose</th>
<th>Continue</th>
<th>Discontinue</th>
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Part A
Do Not Use: U, OD, qd, MS, MSQ4, MgSO4, D, Leeding Decimal (X mg), Trailing Zero (X.0 mg), N, QOD, up

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Part B
Information collected by: ________________________________

☐ Copy given to patient
☐ Patient/Caregiver Signature: ____________________________
☐ Copy faxed to CRMC Health Information Services at 312-6644.
☐ Copy hand delivered to CRMC Health Information Services at 312-6644.

New Prescriptions Ordered and Given to Patient

Nurse: ____________________________ Date/Time: ______________________