Clínica de Medicina de Dolor
Robert Castro Velázquez, MD, DABA
Diplomate of The American Board of Anesthesiology
787-834-2994 | clinica.robertcastro@gmail.com

KETAMINE INFUSION - PATIENT QUESTIONNAIRE

NAME: _____ DATE: _____

Briefly, describe your symptoms:

Name the specialist(s) that you have visited regarding this problem:

1.	2.
3.	4.

Psychiatric Hospitalizations:

Place: Date: Reason: Place: Date: Reason:
Referring doctor:
Primary doctor:
Diagnosis established by your doctor:
Is there any member of your family with a psychiatric history?
Do you use any type of controlled substance? When was the last time?

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What is your intention or goal with this treatment?

Habits: ____ Smoke ____ Coffee _____ Alcohol _____ Illegal Drugs

Sleep: Do you have insomnia? _____YES ___ NO

How many hours do you sleep at night? ___ hrs.

Please mention if you are allergic to any type of medication or food:

_____

Medical History:

High Blood Pressure	Emphysema
Diabetes	Epilepsy
Depression	Kidney Failure
Angina	Circulation
Cirrhosis	Bronchitis
Arthritis	Hepatitis
Heart Attack	Ulcers in the stomach
Asthma	HIV
Stroke	Other:
Thyroid	_____

Medicines:

NAME	DOSE	FREQUENCY
1.		
2.		
3.		
4.		
5.		