

SCREENING FORM FOR SPINE PROCEDURE

Patient: _____

Procedure: _____

Date: _____

Please estimate how far you can walk: _____ ft:

Have you ever had a spinal injection? If so, when and where? Any problems or complications?

Have you ever had a spinal surgery? NONE If so, when and where?:

Please list allergies here or circle: NONE

What medications are you currently taking?

Have you taken any aspirin, Coumadin, Persantine or any other blood thinner in the last week? **NO**

YES: Please list

Have you had any recent infections or taken antibiotics? **NO**

YES

Have you been diagnosed with a chronic infection like bronchitis, sinusitis or kidney disease? **NO**

YES

Do you have any chronic medical conditions such as a heart valve, diabetes or rheumatic fever? **NO**

YES

Have you had any recent dental work, sore teeth, recent dental cleanings or infection? **NO**

YES

Have you ever had any problems with anesthesia? **NO**

YES