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?

Are you pregnant or is there a possibility that you may be pregnant? NO YES

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: Please List

Have you been diagnosed with a chronic infection like bronchitis, sinusitis or kidney disease? NO
YES: Please List

Do you have any chronic medical conditions such as a heart valve, diabetes or rheumatic fever? NO
YES: Please List

Have you had any recent dental work, sore teeth, recent dental cleaning or infections? NO
YES: Please List

Have you ever had any problems with anesthesia? NO
YES: Please List

____

Signature Date