

PRE PROCEDURE CHECK-IN

NAME: _____

DATE: _____

Circle appropriate answers (Please ask for assistance if you do not understand the question)

Y N Is this your first injection for this problem? If no, how many have you had in the last 12 months? _____

Y N Are you diabetic? If Yes, is your blood sugar currently well controlled? Y N

Y N Do you take insulin? Please list your diabetic medications (not doses): _____

Y N Are you taking any blood thinning medications: Plavix, Ticlid, Coumadin/Warfarin, etc?

If yes, what date did you last take the medication? _____

Y N Are you currently taking: Aspirin, Motrin, Advil, Aleve, Naprosyn, Feldene, Relafen or other Non-Steroidal Anti-Inflammatory medications (NSAIDS)?

Please name all the medicines (not doses) you are currently taking: _____

Y N Are you aware of any kidney problems? Explain: _____

Y N Do you currently have any active infection or fever? If yes, what? _____

Y N Are you currently taking antibiotics? If yes, what? _____

Y N Are you allergic to IV contrast or iodine-based dyes?

If yes, did you take a Prednisone and Benadryl prep before coming today? Y N

Y N Do you have any other medication allergies?

If yes, please list: _____

Y N Have you ever had a severe allergic reaction requiring treatment at a hospital?

Y N Are you allergic to latex?

Y N **Female Patients:** Is there any chance you could be pregnant?

IF YES, Please notify staff prior to the procedure.

Y N Are you driving yourself home today? (Select "No" if you brought a driver)

Which physician is currently treating you for this problem? _____

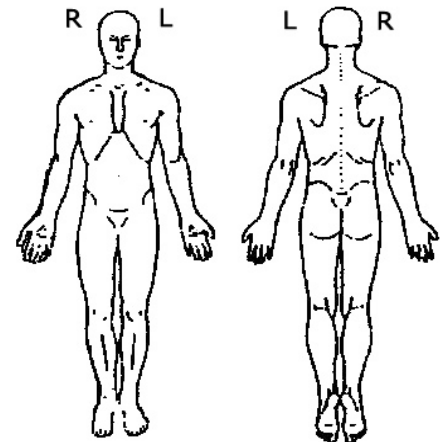
Date of follow-up appointment with that physician after this injection: _____

Patient Signature: _____ Date: _____

Office
Notes:

VITALS	PRE	POST	3__	4__
O2 Sat-				
Pulse-				
BP-				

Please draw the location of your pain on the diagram.
Include any radiation into the arms or legs



What is your pain level TODAY? _____
(0 = No Pain 10 = Worst pain in your life)