PRE-INJECTION QUESTIONAIRE

(Bring this with you the day of your injection)

Patient Name: _____

Have you filled out this questionaire within the last year? ❑ YES ❑ NO *(If you answered no please continue to fill out questionaire.)*

Allergies (drug or food): _____

_____

Current Medication: _____

_____

Previous Surgeries: _____

_____

Do you take aspirin regularly? ❑ YES ❑ NO *(If yes, please follow instruction sheet reguarding stopping aspirin prior to injection.)*

Please check YES or NO if you currently have or have had a history of the following:

			If yes, please explain
Heart Disease, MI, Chest Pain	❑ YES	❑ NO	_____
Irregular Heart Beat	❑ YES	❑ NO	_____
High Blood Pressure	❑ YES	❑ NO	_____
Stroke	❑ YES	❑ NO	_____
Bronchitis, Emphysema, COPD	❑ YES	❑ NO	_____
Asthma	❑ YES	❑ NO	_____
Anemia	❑ YES	❑ NO	_____
Bleeding Problems	❑ YES	❑ NO	_____
Clotting Problems, DVT	❑ YES	❑ NO	_____
Diabetes	❑ YES	❑ NO	_____
Thyroid Problems	❑ YES	❑ NO	_____
Epilepsy or Seizures	❑ YES	❑ NO	_____
Migraines, Headaches	❑ YES	❑ NO	_____
Cancer	❑ YES	❑ NO	_____
Hiatial Hernia, Reflux, Heartburn	❑ YES	❑ NO	_____
Hepatitis, Liver Disease	❑ YES	❑ NO	_____
Kidney/Bladder Problems	❑ YES	❑ NO	_____
Arthritis	❑ YES	❑ NO	_____
Back/Neck Problems	❑ YES	❑ NO	_____
Weakness/Numbness to Extremities	❑ YES	❑ NO	_____
AIDS/HIV	❑ YES	❑ NO	_____
Any other Medical Illnesses	❑ YES	❑ NO	_____
Do you or have you:	❑ YES	❑ NO	_____
Use Tobacco	❑ YES	❑ NO	_____
Drink Alcohol	❑ YES	❑ NO	_____
Use Recreational Drugs	❑ YES	❑ NO	_____

Do you have any special need or impairments? (Religious, Dietary, Cultural, other): _____

_____

OFFICE USE: Form filled out by: _____ RN Signature: _____

ROCKY MOUNTAIN SURGICAL CENTER
1450 Ellis Street, Suite 101
Bozeman, MT 59715
(406) 556-9000 Fax (406) 556-9116

PATIENT NAME: _____ **DOB:** _____

DATE OF PROCEDURE: _____ **TIME:** _____