Delta
SPINE AND PAIN CLINIC

Pre-Evaluation Questionnaire

Age: _____

DRUG ALLERGIES: _____

Have you ever been diagnosed with any of the following: (*Check all that apply*)

____ Procedure experienced large blood loss

____ Cardio Vascular Disease

____ Hypertension

____ COPD

____ Asthma

____ Radiation Therapy/ Chemo

____ Hepatic (Liver) Disease active

____ Renal Disease Active

____ Bleeding Disorder

____ Diabetes

____ Smoking >20 packs/ year

____ Use of Diuretics

____ Malignancy (Current)

____ Use of Anticoagulants (Blood Thinners) – If so, What? _____

Prescribing physician _____Phone:_____

List any past surgeries and approximate dates performed:

Procedure Name	**Date performed**