

PROCEDURE DAY QUESTIONNAIRE

Did you have a procedure at your last visit? YES NO
What procedure did you have? _____
What was your pain score before the procedure (0-10)? _____
What was your pain score immediately after? _____
How long did the pain relief last for? _____

Did you like the results of the procedure? YES NO
Any problems from the procedure? Redness Bleeding Bruising Weakness Numbness
 Increased pain at injection site Other: _____

Would you go through the procedure again? YES NO

List the medications WE are prescribing to you HERE:

NAME OF MEDICATION	DOSE	Is it helpful?	
		YES	NO
_____	_____	YES	NO
_____	_____	YES	NO
_____	_____	YES	NO

1. Have you had anything to EAT or DRINK in the past 6 hours? NO YES
2. Do you have someone to drive you home? YES NO
3. Are you allergic to local anesthetic or iodine? NO YES
4. Are you taking any blood thinners? NO YES
5. Are you diabetic?
 If yes, what and when was your last blood sugar? _____
6. Would you like sedation for this procedure? NO YES
7. Women only, I have had a Hysterectomy Tubal ligation Menopausal
 I decline a pregnancy test despite having none of the above.

Is there anything else you would like to discuss? _____

** Please note that extensive medication management and management of other conditions may require additional documentation separate from today’s procedure and may incur additional charges and copays as mandated by third party payers.

FOR OFFICE USE ONLY:

BEFORE Pain score:	AFTER Pain score:
BP:	BP:
Pulse:	Pulse:
Resp:	SpO2:
SpO2:	
Temp:	
Blood Sugar:	
Pregnancy:	