



## PRE-INJECTION QUESTIONNAIRE

Today's Date \_\_\_\_\_

Which doctor are you seeing today? Edward Shadid, M.D. \_\_\_\_\_ Gentian Meta, M.D. \_\_\_\_\_  
 Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Init.: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Mobile #: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Please check the appropriate box if you have had any of the following medications in the **last seven days**:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Plavix            | <input type="checkbox"/> Ecotrin/Excedrin | <input type="checkbox"/> Celebrex/Vioxx/Bextra |
| <input type="checkbox"/> Coumadin/Warfarin | <input type="checkbox"/> Ibuprofen/Mobic  | <input type="checkbox"/> Fiorinal              |
| <input type="checkbox"/> Lovenox           | <input type="checkbox"/> Advil/Motrin     | <input type="checkbox"/> Ticlodipine           |
| <input type="checkbox"/> Heparin           | <input type="checkbox"/> Naprosyn/Aleve   | <input type="checkbox"/> Aggrenox              |
| <input type="checkbox"/> Asprin/Ecotrin    | <input type="checkbox"/> Naproxen         | <input type="checkbox"/> Darvon CMPD           |

Check One Please specify:

- Do you have any allergies to medications?..... No  Yes -> \_\_\_\_\_
- Have you had anything to eat or drink in the last 6 hours?..... No  Yes -> \_\_\_\_\_
- Are you currently taking an antibiotic? ..... No  Yes -> \_\_\_\_\_
- Have you taken an antibiotic in the last 14 days? ..... No  Yes -> \_\_\_\_\_
- Have you ever been diagnosed with MRSA?..... No  Yes -> \_\_\_\_\_
- Are you a diabetic?..... No  Yes -> \_\_\_\_\_
- Did you take your diabetes medication today?..... Yes  No -> \_\_\_\_\_
- Blood sugar last checked \_\_\_\_\_ value \_\_\_\_\_
- Do you have high blood pressure? ..... No  Yes -> \_\_\_\_\_
- Did you take your B.P. medication today?..... Yes  No -> \_\_\_\_\_
- If female: Could you be pregnant? ..... No  Yes -> \_\_\_\_\_
- Date of last menstrual period ..... -> \_\_\_\_\_
- Did you bring a driver for your injection?..... Yes  No -> Name: \_\_\_\_\_
- Phone #: \_\_\_\_\_
- Is this your first injection?..... Yes  No
- If no, did you have any relief from your last injection? ..... No  Yes  Date of last injection \_\_\_\_\_
- How long did your relief last? ..... -> \_\_\_\_\_
- Check the percent of relief you received:  100%  75%  50%  25% Other \_\_\_\_\_