Pre-Operative Questionnaire

PATIENT INFORMATION	
Patient Name:	Date of Birth: _____/_____/_____
Is there someone here today to drive you home from your procedure?: ☐ Y ☐ N	
If yes, what is their Name:	Relationship:
Driver Signature:	Phone#:
Are you allergic to any medications?: ☐ Y ☐ N	
Are you Diabetic?: ☐ Y ☐ N	
Have you taken any medication that thins your blood within the last 5-7 days?: ☐ Y ☐ N	
Are you currently taking any antibiotics?: ☐ Y ☐ N	
When was the last time you had anything to eat or drink?:	
Do you have an advanced directive?: ☐ Y ☐ N	If yes what kind?: ☐ DNR ☐ Living Will ☐ Medical Power of Attorney
COVID-19 Screening: Are you well today, free of fever or cough?: ☐ Y ☐ N	
Circle the number that best describes your current pain rating on a scale of 0 - 10: (0 being pain free and 10 being the most excruciating pain of your life)	
○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10	

Patient Signature: _____ Date: _____

Consent to Medical Treatment

Patient Name: _____ DOB: _____ Chart #: _____

Medical Services/Procedures: _____

Please Read Carefully

1A. **Authorization:** I authorized Dr. _____ and/or such assistants as may be necessary to perform above mentioned medical services/procedure.

1B. I authorize anesthesia to be given to me with this procedure I am having today. I fully understand the risks and possible complications that may come with anesthesia. I understand anesthesia services may be provided by MVASC, Dayton Anesthesia Associates and/or a third-party contractor

1C. I understand and authorize the use of fluoroscopy to complete my procedure if it is deemed necessary to do so. To the best of my knowledge; I am not currently pregnant.

2. **Explanation Given:** My diagnosis, the nature and purpose of the Medical Services/Procedure, possible alternative methods of treatment, what the procedure is expected to accomplish, risk involved, the possible consequences, and the possibility of complications have been explained to me by my Doctor/Therapist. I have had the opportunity to ask questions, and all questions, which I have asked about the procedure, have been answered in a satisfactory manner. No warranty or guarantee has been made as to the results or cure. I understand that the explanation that I have received is not exhaustive and that more remote, risks and consequences may rise.

Discharge Instructions for Pain Patients

Please Notify us if any of the Following Occurs:

- Redness or swelling at the procedure site (use ice as needed, no heat)
- Drainage from the procedure site
- Oral temperatures above 100 °F
- Headache lasting more than 24 hours (try drinking caffeinated drinks)

☐ **Intercostal Nerve Block** - If you notice any sudden shortness of breath or chest pain go to the emergency room

☐ **Stellate Ganglion Block** - You may have a watery red eye with a smaller pupil on the same side of where the injection was given. You may also have hoarseness and drooping of the eye. These are normal effects of the injection and should dissipate in 4-5 hours.

Next Appointment: ☐ 1 Week ☐ 2 Weeks ☐ Office Visit **For:** _____

Call 937-252-5500 With Any Questions

In the event of an emergency; please call your physician and/or dial 911

Patient Signature: _____ Date: _____

Witness: _____ Date: _____