SAN ANTONIO SPINE CENTER
KEVIN RICHARDSON, D.O.

Spine Surgery Pre-Op Screening Information

Patient Name: _____ Age: _____

Address: _____

Phone #: _____ Occupation: _____

Insurance/Worker's Comp: _____

D.O.S.: _____ Day of Week: _____ Time: _____ L.O.S.: _____

Surgeon: _____ PCP: _____

Consults: _____

Diagnosis: _____

Procedure: _____

Location of Pain: _____

Nature of Pain (burn/ache/etc.): _____

Numbness/Tingling? _____

Pain for how long? _____

Related to an injury? _____ Work related? _____

Currently working? _____ Last day? _____

Past Medical History: _____

_____

_____

_____

Past Surgical History: _____

_____

_____

_____