**Muscle Biopsy Screening Form**

To help us ensure your safety and wellbeing please answer the following questions.

1. Have you ever had a negative or allergic reaction to local freezing (e.g. during dental procedures)?

No 􀀀 Yes 􀀀

1. Do you have any tendency toward easy bleeding or bruising (e.g with minor cuts or shaving)?

No 􀀀 Yes 􀀀

1. Are you currently taking any medications that may increase the chance of bleeding or bruising (e.g. Aspirin, Coumadin, Anti-inflammatories, Plavix)?

No 􀀀 Yes 􀀀

1. Have you ever fainted or do you have a tendency to faint when undergoing or watching medical procedures?

No 􀀀 Yes 􀀀

1. Will you contact the physician who did the biopsy directly if you have any concerns about the biopsy site including: excessive redness, swelling, infection, pain or stiffness of the leg?

No 􀀀 Yes 􀀀

1. Are you willing to visit the physician who did the biopsy 7 – 10 days following the biopsy for an assessment of the biopsy site?

No 􀀀 Yes 􀀀

Subject Name (print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subject Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Person Conducting Assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_