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Fellowship-trained in Pain Management
Double Board Certified in
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MEDICAL HISTORY

DATE: _____

NAME: _____ BIRTH DATE _____ PRIMARY PHYSICIAN _____

HEIGHT _____ WEIGHT _____ PHARMACY NAME/LOCATION _____

Past & Current History (Mark all that apply to you)

❑ Bronchitis	❑ High Blood Pressure	❑ Heart Problems	❑ Asthma
❑ Seizures	❑ Low Blood Pressure	❑ Kidney Trouble	❑ Pulmonary Problems
❑ Emphysema	❑ Shortness of Breath	❑ Hiatal Hernia	❑ Chest Pain
❑ Diabetes	❑ Rheumatic Fever	❑ Ulcers	❑ Arrhythmia
❑ Paralysis	❑ Thyroid Issues	❑ Lupus	❑ Leg Swelling
❑ Back Pain	❑ Tuberculosis (TB)	❑ Stroke	❑ Heart Murmur
❑ Pneumonia	❑ Bleeding Issues	❑ Polio	❑ Sleep Apnea
❑ Hepatitis	❑ Thrombophlebitis	❑ C-PAP Machine	❑ Psychological Problems
❑ Psoriasis	❑ Rheumatoid Arthritis	❑ Pregnancy Complications	

Any Medical Issues that may complicate Anesthesia? ❑ No ❑ Yes _____

Family History (Mark all the apply)

❑ Hypertension ❑ Heart Disease ❑ Diabetes

❑ Rheumatoid Arthritis ❑ Lupus

Please list all Previous Surgeries and Approximate Dates:

_____

_____

Any previous injuries? ❑ Yes ❑ No **If yes, explain injury**. Any work loss? ❑ Yes ❑ No

_____

Are you allergic to any medications? ❑ Yes ❑ No **If yes, what type and describe reaction**.

_____

_____

Please list all medications you are currently taking, including dosage:

_____

_____

Do you smoke? ❑ Yes ❑ No **If yes, amount per day** _____

Do you drink alcohol? ❑ Yes ❑ No **If yes, amount per day** _____

Do you have implanted metal in your body? ❑ Yes ❑ No **If yes, where and Date of procedure** _____

Do you have a pacemaker? ❑ Yes ❑ No Are you claustrophobic? ❑ Yes ❑ No

NSAIDS previous used for pain? ❑ Ibuprofen ❑ Tylenol ❑ Aleve ❑ Naproxen ❑ Motrin

Are you presently taking any of the following: Recreational Drugs? ❑ Yes ❑ No Rx Diet Pills? ❑ Yes ❑ No

Coumadin? ❑ Yes ❑ No Aspirin? ❑ Yes ❑ No Anti Inflammatory? ❑ Yes ❑ No

If you answered yes to any of the above, please describe/amount per day? _____

_____

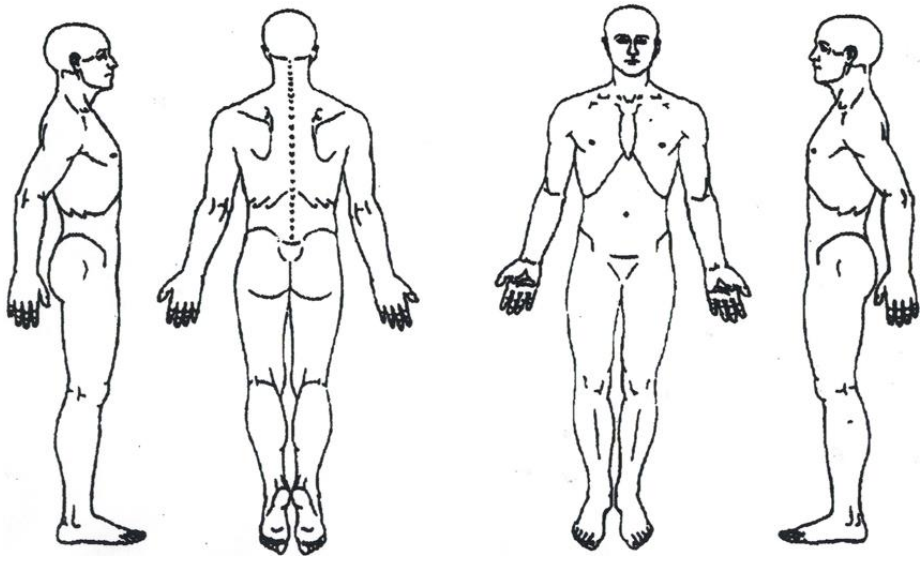
I certify that this information is correct to the best of my knowledge.

_____

Patient or Guardian Signature/Relationship if not Self **Date**

BRIEF PAIN HISTORY

Mark your area(s) of pain on the diagram below and mark an (X) on the area(s) where your pain hurts the MOST.



Please check the words that best describe your pain. ❑ Constant ❑ Intermittent

❑ Aching	❑ Dull	❑ Sharp	❑ Numbing	❑ Burning
❑ Sharp	❑ Stabbing	❑ Tingling	❑ Radiating	❑ Cramping

Have you had physical therapy? ❑ Yes ❑ No **If so when?** _____ **For how long?** _____

Have you ever had injections? ❑ Yes ❑ No **If so when?** _____ **What doctor?** _____

What type? _____

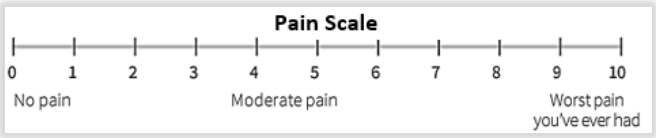
Medications that did NOT work in the past? _____

_____

When tried? _____ Why Stopped? _____

Do you take any pain medications not prescribed by your doctor(s)? ❑ Yes ❑ No **If yes, list:** _____

_____



Please mark the number that best describes your pain at its **WORSE** in the last week.

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Please mark the number that best describes your pain at its **LEAST** in the last week.

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Please mark the number that best describes your pain on **AVERAGE**.

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Please mark the number that best describes your pain **RIGHT NOW**.

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

PATIENT NAME: _____

Last First Middle Initial Date of Birth

In the last week, how much pain relief has pain treatments and/or medications provided?

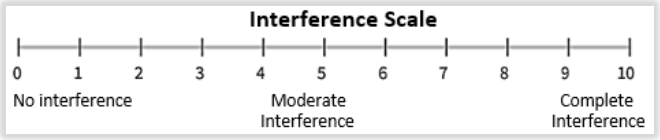
❑ 10% ❑ 20% ❑ 30% ❑ 40% ❑ 50% ❑ 60% ❑ 70% ❑ 80% ❑ 90% ❑ 100%

What makes your pain worse? ❑ Standing ❑ Walking ❑ Sitting ❑ Stress ❑ Other:

_____

What makes your pain better? ❑ Heat ❑ Ice ❑ Medication ❑ Rest ❑ Hypnosis ❑ Other:

_____



Please mark the number that best describes how your pain interferes with the following:

General Activity:	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Mood:	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Walking:	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Standing:	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Sleep:	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Work:	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Relationships:	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Enjoyment of Life:	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10

I certify that this information is correct to the best of my knowledge.

_____ _____

Patient or Guardian Signature/Relationship if not Self **Date**

PATIENT NAME: _____

Last First Middle Initial Date of Birth