

**PAIN MANAGEMENT CENTER
PATIENT HISTORY**

NAME: _____

Please fill in completely (0) all circles (yes and no) as pertaining to your current symptoms.

Constitutional

- Weight gain Yes No
- Fatigue Yes No
- Fever Yes No
- Loss of appetite Yes No

Ophthalmology

- Drainage from eyes Yes No
- Glasses/contacts Yes No
- Excess tearing Yes No
- Eye pain Yes No
- Vision changes Yes No

ENT

- Ear pain Yes No
- Ear discharge Yes No
- Hearing loss Yes No
- Ringing in ears Yes No
- Ear infection Yes No
- Post-nasal drip Yes No
- Sore throat Yes No
- Bleeding gums Yes No

Cardiology

- Chest pain Yes No
- Palpitations Yes No
- Heart murmurs Yes No
- Shortness of breath Yes No

Respiratory

- Cough Yes No
- Wheezing Yes No
- Shortness of breath Yes No

Gastroenterology

- Heartburn Yes No
- Peptic ulcers Yes No
- Nausea Yes No
- Vomiting Yes No
- Diarrhea Yes No
- Constipation Yes No
- Laxative use Yes No
- Jaundice Yes No
- Loss of bowel control Yes No

Urology

- Frequent urination Yes No
- Urinary tract infection Yes No
- Painful urination Yes No
- Urinary retention Yes No
- Urinary dribbling Yes No
- Loss of urinary control Yes No

Musculoskeletal

- Joint pain Yes No
- Joint swelling Yes No
- Joint stiffness Yes No
- Muscle cramps Yes No
- Muscle swelling Yes No

Neurology

- Tingling numbness Yes No
- Tremors Yes No
- Fainting Yes No
- Headache Yes No
- Weakness Yes No
- Dizziness Yes No

Dermatology

- Rash Yes No
- Skin itching Yes No
- Skin infection Yes No

Endocrinology

- Hot flashes Yes No
- Hair loss Yes No
- Always hot Yes No
- Always cold Yes No
- Excessive thirst Yes No

Hematology/Lymph

- Easy bruising Yes No
- Easy bleeding Yes No
- Swollen lymph nodes Yes No
- Anemia Yes No

Allergy/Immune system

- AIDS Yes No
- Allergies Yes No
- Frequent infections Yes No
- Steroid use Yes No
- Hives Yes No

Psychology

- Anxiety Yes No
- Depression Yes No
- Mood swings Yes No
- Nightmares Yes No

Male reproductive

- Difficulty with erection Yes No

Female reproductive

- Pregnant Yes No

Where is your pain located?

- neck
- shoulder
- upper arm
- forearm
- finger
- low back
- headaches
- thigh
- shin
- toes
- ankle
- groin
- chest
- entire arm
- axilla
- elbow
- hand
- abdomen
- ribs
- buttock
- calf
- foot
- heel
- knee
- mid-back
- facial

How long have you had your pain?

- 0-6 months
- 6-12 months
- 1-5 years
- 5-10 years
- longer than 10 years

In the last 2-3 weeks when does your pain occur?

- intermittent (on/off)
- less than 8 hrs/day
- 8-16 hrs/day
- constant

On a scale of 0 to 10, with 10 being the worst pain, mark where the severity of your pain is.

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

Associated numbness Yes No

Associated Tingling Yes No

What was the setting when the problem first occurred?

- alcohol consumption
- animal bite or sting
- infectious process
- birth-related conditions
- emotional stress
- home
- school or campus
- school-related travel
- toxic substance exposure
- prolonged keyboard activity
- repetitive grasping
- repetitive lifting
- running/jogging
- sports (without obvious trauma)
- squatting
- standing
- straining
- throwing
- walking
- twisting
- weight training
- underwater diving
- stroke (CVA)
- surgery
- reaching
- workplace
- medication
- bending over
- climbing stairs
- coughing
- dancing
- driving
- head movement
- lying down
- having sex
- sitting
- sneezing
- none identified

Please describe your pain (quality): aching boring or drilling cold crushing
 gnawing hot nagging penetrating pins and needles pressure raw
 shock-like shooting sore stinging throbbing tightness burning
 stabbing mild heaviness dull moderate sharp cramping
 severe other quality cannot be determined

Please indicate those activities that INCREASE your pain: (check all that apply)

work walking bending lying flat standing sitting stress
 alcohol consumption foods or beverages locale (i.e. home/work/etc.)
 lying on affected side medications menstrual cycle physical activities
 recreational drug use sleep-related factors toxic substance exposure travel
 underwater diving weight gain other

Please indicate those activities that DECREASE your pain: (check all that apply)

walking standing rest applying heat applying cold injections
 sitting down physical therapy relaxation exercises lying flat
 bending medications emergency room treatment elevating the affected area
 position change non weight bearing supporting the extremity avoiding stress
 massage moving the area continuously sleeping nothing other

Associated signs/symptoms: bleeding bone misalignment cramping

dizziness drainage drop objects fatigue fever joint problems
 language difficulty mental status change muscle tightness muscle weakness
 nausea numbness pain paralysis poor sleep swelling none

Does your pain affect: your quality of life sleep

How many ER visits have you had in the last 3 months for pain?

1 2 3 4 5 more than five none

Do you take any of the following anticoagulants? (check all that apply)

coumadin heparin plavix fragmin lovenox enoxaparin
 normiflo ardeparin orgaran danaparoid

Imaging studies in the last 5 years CT scan EMG (electromyogram) IVP

MRI scan Myelogram X-rays Other tests None

Have you tried any of these therapies: acupressure acupuncture biofeedback

chiropractics elevation exercise heat ice intradiscal therapy
 massage nerve stimulation occupational therapy relaxation surgery
 none

Have you tried any of these pain clinic treatments: injection therapy medications

physical therapy other pain centers psychotherapy none

Have you tried the following NSAIDS to help relieve your pain: ibuprofen aleve

advil naproxen celebrex toradol indocin

Are you on Workers Comp? Yes No

Mark the appropriate information related to Worker's Compensation:

work related travel trauma and/or injury unable to work at all since the injury
 able to work with restrictions since the injury temporary limitations after the injury
 no restrictions now no work restriction since the injury

Litigation pending: Yes No

If you are involved in any lawsuits, who is the lawsuit against? (Check all that apply)

Worker's Compensation Auto accident Disability claim Other

Have you been to any of the following types of doctors?

Back Surgeon Neurologist Rheumatologist Other pain doctor

Past Medical History

| | | | |
|---------------------------|--|---------------------------|--|
| Heart disease | <input type="radio"/> Yes <input type="radio"/> No | Asthma | <input type="radio"/> Yes <input type="radio"/> No |
| Seizures | <input type="radio"/> Yes <input type="radio"/> No | HTN | <input type="radio"/> Yes <input type="radio"/> No |
| Anxiety disorder | <input type="radio"/> Yes <input type="radio"/> No | Tumor or Cancer | <input type="radio"/> Yes <input type="radio"/> No |
| Migraine headaches | <input type="radio"/> Yes <input type="radio"/> No | Lung disease | <input type="radio"/> Yes <input type="radio"/> No |
| Colitis | <input type="radio"/> Yes <input type="radio"/> No | Pancreatitis | <input type="radio"/> Yes <input type="radio"/> No |
| Rheumatic fever | <input type="radio"/> Yes <input type="radio"/> No | Bleeding disorder | <input type="radio"/> Yes <input type="radio"/> No |
| Tension headache | <input type="radio"/> Yes <input type="radio"/> No | Autoimmune disorder | <input type="radio"/> Yes <input type="radio"/> No |
| Bladder/kidney disease | <input type="radio"/> Yes <input type="radio"/> No | Arthritis | <input type="radio"/> Yes <input type="radio"/> No |
| Stroke | <input type="radio"/> Yes <input type="radio"/> No | Diabetes | <input type="radio"/> Yes <input type="radio"/> No |
| Peptic Ulcer disease | <input type="radio"/> Yes <input type="radio"/> No | Anemia/blood disorder | <input type="radio"/> Yes <input type="radio"/> No |
| Neurological disease | <input type="radio"/> Yes <input type="radio"/> No | Liver/gallbladder problem | <input type="radio"/> Yes <input type="radio"/> No |
| Thyroid/endocrine problem | <input type="radio"/> Yes <input type="radio"/> No | | |

Family History

Is your father still alive? Yes No
Is your mother still alive? Yes No
Do you have children or other dependents at home? Yes No

Social History

What is your marital status? Married Single Divorced Widowed
Are you currently employed? Yes No
Are you on Disability? Yes No
What type of disability do you have?
 Short term Long term Social Security Other

Do you use alcohol to control your pain? Yes No

Mark if you use any of the following drugs recreationally:

Amphetamines Barbituates Cocaine Codeine Diazepam Heroin
 Hydrocodone Marijuana Oxycodone Soma

Dependency or addiction to drugs now or in the past? (Check all that apply)

Amphetamines Barbituates Cocaine Codeine Diazepam Heroin
 Hydrocodone Marijuana Morphine Oxycodone Soma

