physicianpaincare

Medical History Form

NAME _____

Height _____ **Weight** _____

MEDICATIONS: List all medications you are currently prescribed.

Name	Dosage	Frequency

List all non-prescription drugs and frequency of usage:

_____

Are you on a blood thinner? (Coumadin, Warfarin, Lovanox, Plavix) **If yes, what medication**? _____

Have you been treated for any of the following medical conditions? Check all that apply.

___ Anemia	___ Diabetes	___ Gastroesophageal Reflux
___ Angina, Heart Blockage	___Epilepsy or Seizure	___ GI Bleed
___ Anxiety	___ High Blood Pressure	___ Heart Attack/MI
___ Asthma	___ High Cholesterol	___ Heart Rhythm problems
___ Mental Illness (bipolar, schizophrenia)	___Kidney Disease or stones	___ Hepatitis
___Cancer Type_____	___ Lupus	___Sleep Apnea
___ Cirrhosis of Liver	___Migraine Headaches	___ Stomach Ulcer
___Congestive Heart Failure	___ Multiple Sclerosis	___ Stroke/CVA
___ COPD or Emphysema	___ Pancreatitis	___ Thyroid Dysfunction
___ Depression	___Shingles	___ HIV

Do you have any allergies to medications, immunizations, foods? List all that apply:

_____

_____

_____

Are you allergic to contrast dye? YES NO **Are you allergic to Latex?** YES NO

Are you allergic to Betadine? YES NO **Do you have ANY known allergies?** YES NO

List any/all surgeries you have had and the year they were performed: _____

_____

_____

_____

_____

List any overnight hospitalizations you have had for reasons other than surgery, with year they were performed:

_____

_____

_____

_____

Have any family members had the following medical problems? Check all that apply:

___ Heart Disease ___ Substance Abuse or Alcoholism

___ Stroke ___ Arthritis

___ Cancer Other: _____

Are you experiencing any of these symptoms? Check all that apply.

___ Weight change	___ Cough	___ Tremors
___ Fatigue	___ Shortness of breath	___ Joint pain or stiffness
___ Fever	___ Blood in stool	___ Muscle cramps
___ Loss of appetite	___ Constipation	___ Abnormal bleeding or bruising
___ Loss of vision	___ Nausea or vomiting	___ Enlarged lymph nodes
___ Depression	___ Loss of bowel/bladder control	___ Painful skin sensitivity
___ Chest Pain	___ Headache	___ Excessive sweating
___ Swelling of legs	___ Seizures	___ Rash
___ Stress/Anxiety	___ Insomnia	

Are you currently employed? YES NO **Retired?** YES NO **Disabled?** YES NO

Most recent occupation? _____

Do you smoke? _____ **Number of years**? _____ **How many per day**? _____ **Year you quit?**_____

Do you chew tobacco? _____ **No. of years** _____ **Do you drink alcohol**? _____ **Drinks per week** _____

Do you use drugs recreationally? _____ **Which drug**? _____

Do you have a dependency on any prescription drugs? _____

Have you ever been treated for drug addiction? _____ **If yes, what was your addiction, and when were you treated?**

Describe the pain that brings you in today: _____

When did your pain begin? _____

Was there a specific cause for your pain? YES NO **If so, please describe:** _____

_____

Did you have a work related injury? YES NO **Have you pursued legal action for an injury?** YES NO

If part of a legal case, is the case pending or resolved? _____

Please circle the word (s) that best describes your pain: ACHING BURNING GNAWING SHARP SHOOTING

SPASM OTHER_____

Does your pain radiate to another area? YES NO **If yes, where does it radiate?** _____

On a scale of 1 to 10, with 10 being the worst pain, what is the present severity of your pain? _____

What is the maximum severity, when your pain is at its worst? _____

Does your pain interfere with your daily activities? NO MILDLY MODERATELY SEVERELY

Does your pain affect your sleep? YES NO

Is your pain: CONSTANT/STEADY

INTERMITTENT (COMES & GOES)

CONSTANT WITH TIMES WHEN ITS WORSE

Is there a time of day when your pain is better or worse? If so, please describe:

What makes your pain worse?_____

What relieves your pain? _____

Do you have any of the following with your pain?

weakness numbness tingling skin sensitivity bowel or bladder problems skin color change

If yes, please describe what area of your body is affected:

_____

Have you been treated by another pain management doctor in the past? YES NO

If so, who? _____

Have you had an MRI of your back? YES NO **Location of MRI:** low back neck thorax

Approximate date of MRI: _____ **Where was it done?**_____

Please check the following that apply to your current pain condition:

Physical Therapy Did it help? _____ When was it last done? _____

TENS Unit Did it help? _____

Epidural injection Did it help? _____ How long did your relief last? _____

Radiofrequency Did it help? _____ How long did your relief last? _____

Other _____

What medications have been used to treat your pain, and were they beneficial?

_____

_____

_____

What do you expect from your visit today?

_____

_____

_____