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	O Yes	O No
Fatigue	O Yes	O No
Fever	O Yes	O No
Loss of appetite	O Yes	O No

Ophthalmology

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

ENT

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

Cardiology

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

Respiratory

Cough	O Yes	O No
Wheezing	O Yes	O No
Shortness of breath	O Yes	O No

Gastroenterology

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

Urology

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

Musculoskeletal

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

Neurology

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

Dermatology

Rash	O Yes	O No
Skin itching	O Yes	O No
Skin infection	O Yes	O No

Endocrinology

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

Hematology/Lymph

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

Allergy/Immune system

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

Psychology

Anxiety	O Yes	O No
Depression	O Yes	O No
Mood swings	O Yes	O No
Nightmares	O Yes	O No

Male reproductive

Difficulty with erection	O Yes	O No

Female reproductive

Pregnant	O Yes	O No

Where is your pain located?

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

How long have you had your pain?

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

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

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

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

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

Associated numbness O Yes O No

Associated Tingling O Yes O No

What was the setting when the problem first occured?

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

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

Please indicate those activities that INCREASE your pain: (check all that apply)
O work O walking O bending O lying flat O standing O sitting O stress
O alcohol consumption O foods or beverages O locale (i.e. home/work/etc.)
O lying on affected side O medications O menstrual cycle O physical activites
O recreational drug use O sleep-related factors O toxic substance exposure O travel
O underwater diving O weight gain O other

Please indicate those activities that DECREASE your pain: (check all that apply)
O walking O standing O rest O applying heat O applying cold O injections
O sitting down O physical therapy O relaxation exercises O lying flat
O bending O medications O emergency room treatment O elevating the affected area
O position change O non weight bearing O supporting the extremity O avoiding stress
O massage O moving the area continuously O sleeping O nothing O other

Associated signs/symptoms: O bleeding O bone misalignment O cramping
O dizziness O drainage O drop objects O fatigue O fever O joint problems
O language difficulty O mental status change O muscle tightness O muscle weakness
O nausea O numbness O pain O paralysis O poor sleep O swelling O none

Does your pain affect: O your quality of life O sleep

How many ER visits have you had in the last 3 months for pain?
O 1 O 2 O 3 O 4 O 5 O more than five O none

Do you take any of the following anticoagulants? (check all that apply)
O coumadin O heparin O plavix O fragmin O lovenox O enoxaparin
O normiflo O ardeparin O orgaran O danaparoid

Imaging studies in the last 5 years O CT scan O EMG (electromyogram) O IVP
O MRI scan O Myelogram O X-rays O Other tests O None

Have you tried any of these therapies: O acupressure O acupuncture O biofeedback
O chiropractics O elevation O exercise O heat O ice O intradiscal therapy
O massage O nerve stimulation O occupational therapy O relaxation O surgery
O none

Have you tried any of these pain clinic treatments: O injection therapy O medications
O physical therapy O other pain centers O psychotherapy O none

Have you tried the following NSAIDS to help relieve your pain: O ibuprofen O aleve
O advil O naproxen O celebrex O toradol O indocin

Are you on Workers Comp? O Yes O No

Mark the appropriate information related to Worker's Compensation:
O work related travel O trauma and/or injury O unable to work at all since the injury
O able to work with restrictions since the injury O temporary limitations after the injury
O no restrictions now O no work restriction since the injury

Litigation pending: O Yes O No

If you are involved in any lawsuits, who is the lawsuit against? (Check all that apply)
O Worker's Compensation O Auto accident O Disability claim O Other

Have you been to any of the following types of doctors?
O Back Surgeon O Neurologist O Rheumatologist O Other pain doctor

Past Medical History

Heart disease	O Yes O No	Asthma	O Yes O No
Seizures	O Yes O No	HTN	O Yes O No
Anxiety disorder	O Yes O No	Tumor or Cancer	O Yes O No
Migraine headaches	O Yes O No	Lung disease	O Yes O No
Colitis	O Yes O No	Pancreatitis	O Yes O No
Rheumatic fever	O Yes O No	Bleeding disorder	O Yes O No
Tension headache	O Yes O No	Autoimmune disorder	O Yes O No
Bladder/kidney disease	O Yes O No	Arthritis	O Yes O No
Stroke	O Yes O No	Diabetes	O Yes O No
Peptic Ulcer disease	O Yes O No	Anemia/blood disorder	O Yes O No
Neurological disease	O Yes O No	Liver/gallbladder problem	O Yes O No
Thyroid/endocrine problem	O Yes O No		

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

Social History

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

Do you use alcohol to control your pain? O Yes O No

Mark if you use any of the following drugs recreationally:
O Amphetamines O Barbituates O Cocaine O Codeine O Diazepam O Heroin
O Hydrocodone O Marijuana O Oxycodone O Soma

Dependency or addiction to drugs now or in the past? (Check all that apply)
O Amphetamines O Barbituates O Cocaine O Codeine O Diazepam O Heroin
O Hydrocodone O Marijuana O Morphine O Oxycodone O Soma

Please mark your pain area(s) on this diagram.