PATIENT HEALTH HISTORY

Pain Medicine Associates, P.A.

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Pain Management

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(Please print and complete in entirety)

Date: ____________________

Name: ____

Sex: O Male O Female Birth date: ________________ Age _____

Chief complaint: ____

Location of pain: ____

Beginning of painful condition ____

Quality of pain: O Sharp O Dull O Intermittent O Constant
O Tingling O Numbness O Burning O Throbbing
O Cramping O Spasms

Made worse by: O Sitting O Standing O Walking
O Flexing O Extending O Straining
O Sneezing O Coughing O Deep breathing
O Light stroking of skin

Made better by: O Sitting O Rest O Medication

What is your current level of pain? 1-10________________

Highest level of pain in the last 1 month?1-10______________

Lowest level of pain in the last 1 month? 1-10______________

Average Level?1-10__________

Time of day your pain is worse: O Morning O Afternoon O Evening O Night
O Pain is always same O Varies

Have you had any weakness? Generalized ____________________ Specific ____________________

Have you had any bowel or bladder changes? O Yes O No

Have you had any paralysis? O Yes O No

Have you noticed any of the following changes ***in the painful area***?

O Swelling O Temperature changes O Cold O Hot
O Hypersensitivity to light touch or clothing O Paleness or mottling of the skin

Sleep pattern: O Poor O Good O Interrupted

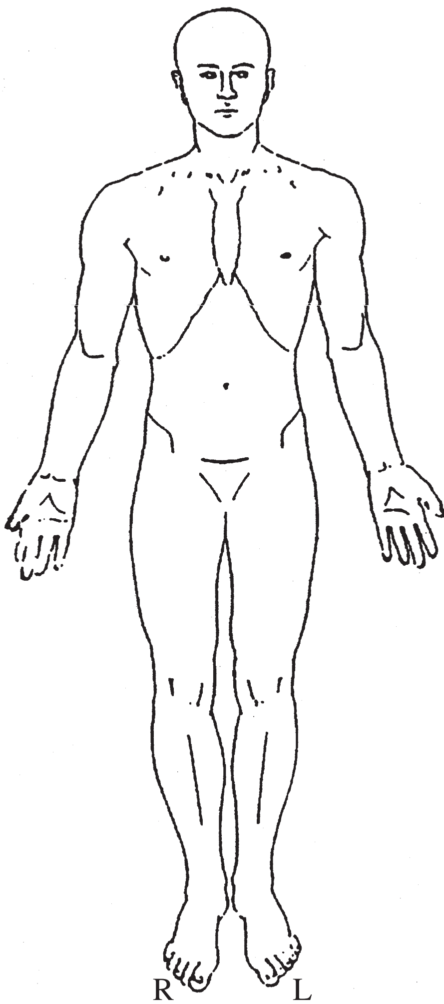
Modifying Factors: Circle the number that best describes the amount of pain relief that treatment is providing or has provided in the past.

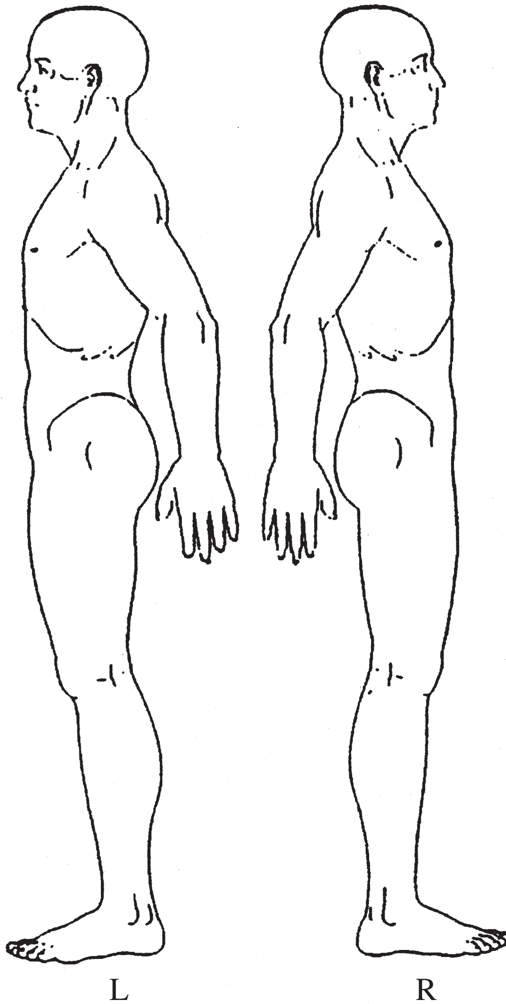
	Never Tried	No Relief										Complete Relief	√ Receiving Now
Physical Therapy	❑	0	1	2	3	4	5	6	7	8	9	10	❑
Surgery	❑	0	1	2	3	4	5	6	7	8	9	10	❑
Injection/Nerve Block	❑	0	1	2	3	4	5	6	7	8	9	10	❑
Drug/Medication Therapy	❑	0	1	2	3	4	5	6	7	8	9	10	❑
Chiropractic Adjustments	❑	0	1	2	3	4	5	6	7	8	9	10	❑
TENS	❑	0	1	2	3	4	5	6	7	8	9	10	❑
Acupuncture	❑	0	1	2	3	4	5	6	7	8	9	10	❑
Biofeedback	❑	0	1	2	3	4	5	6	7	8	9	10	❑
Other________________	❑	0	1	2	3	4	5	6	7	8	9	10	❑

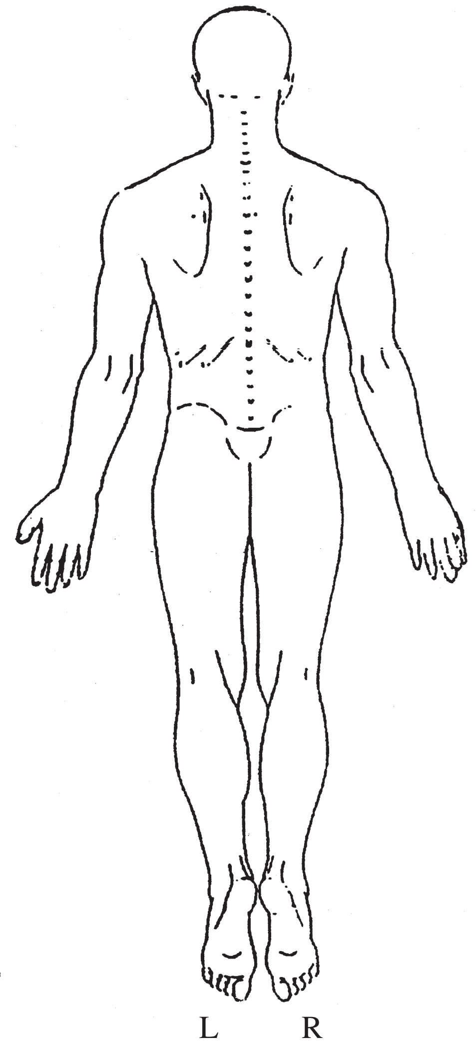
PATIENT INSTRUCTIONS FOR COMPLETING PAIN CHART

Please describe and draw your pain as best you can, by ***filling in the areas*** on the charts ***where you are having pain***, ***and indicating by number the intensity*** of pain. If you have any areas of ***numbness***, please ***indicate areas by an "X"***.

1 - Very mild
2 - Mild
3 - Tolerable
4 -
5 - Moderate
6 -
7 - Severe
8 -
9 - Excruciating
10 - Incapacitating







Explain if necessary: ______________________________

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Level of Difficulty (Please Circle)				
Climbing up a flight of stairs:	None	Some	A lot	Cannot do
Getting up from a chair:	None	Some	A lot	Cannot do
Lifting or carrying:	None	Some	A lot	Cannot do
Moving from chair to bed:	None	Some	A lot	Cannot do
Walking:	None	Some	A lot	Cannot do
Housework:	None	Some	A lot	Cannot do
Making meals:	None	Some	A lot	Cannot do

Fill in health information about your family							
Relation	Age	State of Health	Age at Death	Cause of Death		Check if your blood relatives had any of the following	
Father						Disease	Relationship to you
Mother						Arthritis, Gout	
Brother						Asthma, Hay Fever	
Brother						Cancer	
Brother						Drug Addiction	
Sister						Diabetes	
Sister						Heart disease, Strokes	
Sister						Kidney Disease	
						Tuberculosis	
						Other	

Do you have any allergies to medication? ○ Yes ○ No

List: ______________________________

Current Medications - List all drugs you are *currently taking.* (use additional sheet if needed)

Medication	Condition for which prescribed	Dosage (mg.)	X per day	Effectiveness
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				

SOCIAL HISTORY (please circle)				
Married	Single	Divorced	Widowed	# of Children _____
Smoking	Packs per day:			Quit date:
Alcohol	How many glasses?			Times per day/week
Drugs	Have you ever used drugs? Y N			Currently using? Y N
Explain:				
Have you ever been treated for drug or alcohol abuse? Y N				
Caffeine	Cups per day:		Exercise Y N	How often:
Hobbies:				

Anaesthetic - Related History	Yes or No
Have you ever had a reaction to a local or general anesthetic?	Y / N
If so, what kind? ______________________	
Has a member of your family had a reaction to any anaesthetic?	Y / N
If so, what kind? ______________________	
Are you pregnant or is there ANY chance you might be pregnant?	Y / N
Do you have difficulty extending your neck?	Y / N
Can you open your mouth wide?	Y / N
Do you snore?	Y / N
Do you have any loose, capped or false teeth?	Y / N

Other Physicians involved in your medical care:

Physician	Address	Zip Code	Phone
Primary Care:			
Other:			

*Please **complete the pain chart** on the following page.*

SYMPTOMS **Check ( ) symptoms you have or have had in the past year.**

GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	HEMATOLOGIC
Chills	Appetite poor	Blurred vision	Anemia
Fatigue	Bloating/gas	Diminished eye sight	Bleeding problem
Fever	Ulcer	Dry eye	Prior transfusions
Headaches	Constipation	Eye itching/ redness	Easy bruisability
Lightheadedness	Diarrhea	Eye pain	**NEUROLOGIC**
Night sweats	Hemorrhoids	Hoarseness	Tingling/numbness
Trouble sleeping	Indigestion/heartburn	Difficulty swallowing	Tremor
Weight loss	Nausea	Dry mouth	Memory problems
Weight gain	Rectal bleeding/blood in stool	Sore throat	**PSYCHIATRIC**
Nervousness/anxiety	Stomach pain	Hearing loss	Anxiety
Feeling ill	**CARDIOVASCULAR**	Ringing in ears	Depressed Mood
MUSCLE, JOINT, BONE Pain, weakness, numbmness	Chest pain	**RESPIRATORY**	Hallucination
	High blood pressure	Cough	Suicidal ideas
Arms	Irregular heart beat/Palpitation	Shortness of breath	**BREAST**
Back	Poor circulation	Wheezing	Breast lump
Feet	Swelling of ankles, legs, feet	**SKIN**	Nipple discharge
Hands	**GENITO-URINARY**	Hair loss	**ENDOCRINE**
Hips	Blood in urine	Dry skin	Cold intolerance
Legs	Frequent urination	Rashes	Excessive sweating
Neck	Lack of bladder control	Hair/nail changes	Excessive thirst
Shoulders	Painful urination		Irregular menses
ALLERGY / IMMUNOLOGY	Kidney stones		
Hives	Erectile dysfunction		
Itching	Hot flashes		

CONDITIONS **Check ( ) conditions you have had.**

Acid reflux	Drug addiction	Lyme disease	Scarlet fever
Alcoholism	Emphysema	Measles	Sexual dysfunction
Anemia	Epilepsy	Mental illness	Shingles
Arthritis	Erectile dysfunction	Migraine headaches	STD's: ________________ ______________________
Asthma	Glaucoma	Miscarriage	
Bladder infection	Goiter	Mononucleosis	
Bleeding disorders	Gout	Multiple Sclerosis	Stroke
Blood clots	Heart disease/attack	Mumps	Suicide attempt
Breast lump	Hernia	Pacemaker	Thyroid problems
Bronchitis	Herpes	Parkinson's	TIA's
Bulimia	High blood pressure	Pneumonia	Tonsilitis
Cancer	High cholesterol	Polio	Tuberculosis
Cataracts	HIV Positive	Prostate problem	Ulcers
Chicken pox	Kidney disease	Psychiatric care	Vaginal infections
Diabetes	Liver disease	Rheumatic fever	Venereal disease

PAST SURGICAL HISTORY **Check ( ) any surgeries you have had.**

Neck?	Date:	Surgeon:	
Mid Back?	Date:	Surgeon:	
Low Back?	Date:	Surgeon:	
Appendix	Cancer ______________	Hysterectomy	Stents
Arthroscopy	Coronary bypass	Joint replacement	Tonsils
Breast Biopsy	Gallbladder	Prostate	Wisdom teeth
Fractures:			