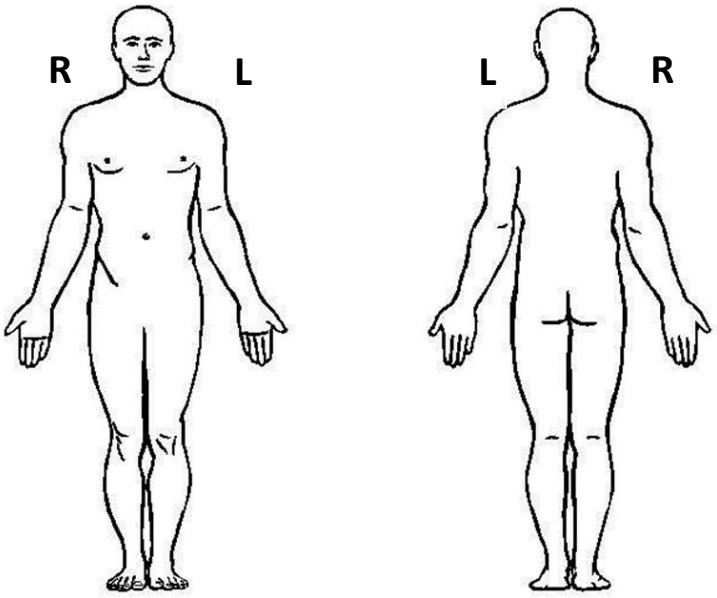
PACIFIC PAIN MEDICINE CONSULTANTS

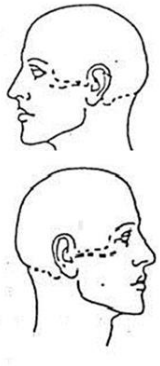
PATIENT HISTORY FORM

1. Name:_____ Date:_____ Age:_____Ht:_____Wt:_____
2. What problem are you here for today? _____
3. Date of onset (first episode):_____ Work related? □ **Yes** □ **No**
4. Explain how the pain started (i.e. suddenly or gradually)?_____

   _____
5. How did this happen? (please be specific about accidents, injuries, etc.) _____
6. Recently, is your pain getting better, worse or about the same? _____ Time frame? _____
7. Location of most significant pain:_____
8. Using the symbols given below, mark the areas on your body where you have your chief pain complaint.



Aching	▲▲▲
Numbness	= = =
Pins & Needles	0 0 0
Burning	XXX
Stabbing	/ / /
Other_____	●●●



9. How would you break down the components of your pain? (***Total to equal 100%)***

Head:	_____%	Abdomen:____%		Pelvis:	_____%	Other:	_____%
Neck:	_____%	Lt. Arm: _____ %		Rt. Arm:	_____%		
Back:	_____%	Lt. Leg: _____%		Rt. Leg:	_____%		

10. What does the pain feel like? (circle) Sharp, Burning, Aching, Stabbing, Other:_____
11. How often have you been experiencing this pain? (circle) Constant, Frequent, Intermittent, Occasional

Please circle the most accurate score with each question: (0=no pain, 10=worst pain imaginable)

Worst pain in the last 7 days?	0	1	2	3	4	5	6	7	8	9	10
Least pain in the last 7 days?	0	1	2	3	4	5	6	7	8	9	10
What is your average pain?	0	1	2	3	4	5	6	7	8	9	10

12. Does your pain radiate/travel to another body region? □ **Yes** □ **No** Where?_____
13. Do you have numbness or tingling? _____ If yes, where? _____
14. Does the affected extremity feel weak? _____If yes, where? _____
15. Does the pain wake you at night?_____
16. Are you able to control urination? □ **Yes** □ **No** Are you able to control bowels? □ **Yes** □ **No**
17. What makes your pain BETTER? (Circle any that apply) Walking, Standing, Sitting, Lying Down, or Other_____
18. What makes your pain WORSE? (Circle any that apply) Walking, Standing, Sitting, Lying Down, Lifting, Turning/Twisting, Coughing, Bending, Other:_____
19. Do you currently have difficulties with any of the following? Dressing, bathing, grooming, household activities, recreational activities, etc.?

Recently, how much has your pain interfered with the following? 0 = Does not interfere 10= Completely interferes

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 Ability?	0	1	2	3	4	5	6	7	8	9	10
Normal work?	0	1	2	3	4	5	6	7	8	9	10
Personal Relationships?	0	1	2	3	4	5	6	7	8	9	10
Sleep?	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

Have you been evaluated by:

Orthopedic surgeon?	YES	NO	Name:_____
Rheumatologist?	YES	NO	Name:_____
Psychiatrist?	YES	NO	Name:_____
Psychologist?	YES	NO	Name:_____
Neurologist?	YES	NO	Name:_____
Pain Management?	YES	NO	Name:_____
Neurosurgeon?	YES	NO	Name:_____
Other specialist?	YES	NO	Name:_____

<u>Medications</u>: Please indicate CURRENT and PREVIOUS pain medication therapies and results:

Check if currently taking. Check if the medication was helpful or not helpful and list any side effects you experienced.

	Currently	Helpful	Not Helpful	Side Effects (if any)
Anti-inflammatory				
□ Ibuprofen (Motrin, Advil)				
□ Naproxen (Naprosyn, Aleve, Naprelan)				
□ Diclofenac (Lodine, Voltaren)				
□ Meloxicam (Mobic)				
□ Celecoxib (Celebrex)				
□ Tylenol				
Muscle Relaxants				
□ Cyclobenaprine (Flexeril, Amrix)				
□ Metaxalone (Skelaxin)				
□ Methocarbamol (Robaxin)				
□ Baclofen				
□ Tizanidine (Zanaflex)				
□ Carisoprodol (Soma)				
Anti-Neuropathics				
□ Gabapentin(Neurontin, Gralise, Horizant)				
□ Pregabalin (Lyrica)				
□ Topiramate (Topamax)				
□ Tegretol/Trileptal				
SNRIs				
□ Duloxetine (Cymbalta)				
□ Venlafaxine (Effexor)				
□ Milnacipran (Savella)				
Topical patches and creams				
□ Lidocaine (Lidoderm)				
□ Diclofenac (Flector, Pennsaid, Voltaren)				
□ Compounded creams				
Other				
□				
□				

Please indicate previous pain therapy:	**Relief**					
	Worse	**None**	**Mild**	**Moderate**	**Profound**	**N/A**
Heat or Ice:_____	-1	0	1	2	3	□
Physical Therapy (Last Visit: _____)	-1	0	1	2	3	□
TENS (neurostimulator): _____	-1	0	1	2	3	□
Home exercises:_____	-1	0	1	2	3	□
Psychological counseling:_____	-1	0	1	2	3	□
Chiropractic treatments:_____	-1	0	1	2	3	□
Acupuncture/Acupressure:_____	-1	0	1	2	3	□
Injections: What type:_____	-1	0	1	2	3	□
Surgery:_____	-1	0	1	2	3	□

PATIENT HISTORY FORM

This medical history can be of critical importance to you and your provider. Please complete it to the best of your ability.

PAST MEDICAL HISTORY: List current and past medical diagnoses

Neurologic: (i.e. Migraines, Stroke, Seizures, Neuropathy, etc.) _____

Respiratory: (i.e. COPD, Asthma, Sleep Apnea, etc.) _____

Cardiac: (i.e. High Blood Pressure, Heart Attack, Arrhythmia, CHF, etc.) _____

Gastrointestinal: (i.e. Ulcers, IBS, Colitis, Hepatitis, Liver Disease, etc.) _____

Kidney: (i.e. Renal Failure, Renal Stones, etc.) _____

Rheumatologic: (i.e. Rheumatoid Arthritis, Lupus, Fibromyalgia) _____

Orthopedic: (i.e. Osteoporosis, Osteoarthritis, etc.) _____

Cancer: _____

Bleeding: (i.e. Blood Clots, Anemia, Bleeding Disorder) _____

Endocrine: (i.e. Diabetes, Thyroid disease, Hormone Abnormalities, Low Testosterone, etc.) _____

Dermatologic: (i.e. Shingles, Psoriasis, Eczema, etc.) _____

Psychologic: (Depression, Anxiety, ADHD, Schizophrenia, Bipolar, Substance Abuse, etc.) _____

PAST SURGICAL HISTORY: Please list any operations and indicate the approximate date or your age at the time of the procedure.

Operation:	Date:

MEDICATION ALLERGIES: (Please include iodine or x-ray contrast)

Medication:	Effect (i.e., hives, swelling, itching):

MEDICATIONS: List all medications (including non-prescription) which you are <u>taking now</u>. Give dose and frequency. (*check bottle if necessary.)* **Please print**

Medication / Drug:	Amount or Dose:	Frequency:

Are you taking any blood thinning medications? Please check the appropriate box

□ Not taking any blood thinners

□ Coumadin (Warfarin)
□ Ticlid (Ticlopidine)
□ Agrylin (Anagreline)
□ Plavix (Clopidogrel)
□ Arixtra (Fondiparinux)
□ Elmiron (Pentosan)
□ Aggrenox (Dipyridamole/ASA)
□ Pletal (Cilostazol)
□ Reopro (Abciximab)
□ Lovenox (Enoxaparin)
□ Effient (Prasugrel)
□ Trental (Pentoxifyline)
□ Fragmin (Dalteparin)
□ Pradaxa (Dabigatran)
□ Brilinta (Ticagrelor)
□ Heparin
□ Xarelto (Rivaroxaban)
□ Aspirin

Have you ever stopped the medication for a procedure in the past? □ **Yes** □ **No**

Which provider is currently prescribing the blood thinner for you?

SOCIAL HISTORY

□ Married □ Single □ Divorced □ Widowed

Spouse's name:_____

Living situation (alone, with family, nursing facility, etc.) _____

Please indicate your approximate use or intake of the following:

Coffee: _____ cups/day

Tobacco Use: □ Cigarettes/Cigar/Pipe □ E-Cig/Vape □ Smokeless Tobacco □ Never Used Tobacco/Smoked

□ Current Smoker/Tobacco user _____ per day □ Former Smoker When quit?_____

Recreational Drugs, Toxic or Potentially Harmful Substances (Methamphetamine, Heroine, Cocaine, Ecstacy, Others)

□ Never □ Former □ Current Substances Used _____

Marijuana Use: □ Recreational □ Medicinal Last use: _____ □ Never used

Alcohol Use: Number of Alcohol drinks per week? □ Beer _____ □ Wine_____ □ Liquor _____

Occupation:_____□ Current □ Former

Type of physical activity at work:_____

Have you ever been on disability for this condition?_____

Work Compensation Claim or Litigation Involving Injury: Prior, present, pending or anticipated?_____

FAMILY HISTORY: Please mark an "X" in the appropriate boxes for each person.

PROBLEM	Grandfather	Grandmother	Father	Mother	Son(s)	Daughter(s)	Sibling
Diabetes							
Heart Disease							
Cancer							
Neurological Diagnosis							
Rheumatologic							
Chronic Pain							
Fibromyalgia							
Mental Illness							
Alcohol abuse							
Illicit Drug abuse							
Prescription Drug abuse							
Suicide							

CHECKLIST:
Review of Systems

General -
□ Weight Loss Or Gain
□ Fatigue
□ Fever or Chills
□ Weakness
□ Trouble Sleeping

Skin -
□ Rashes
□ Lumps
□ Color Changes
□ Hair and Nail Changes

Head-
□ Headache
□ Head Injury
□ Neck Pain

Ears –
□ Decreased Hearing
□ Ringing in Ears
□ Nose Bleeds
□ Sinus Pain
□ Cataracts

Eyes –
□ Vision Loss/Changes
□ Glasses or Contacts
□ Pain
□ Redness
□ Blurry or Double Vision
□ Flashing Lights
□ Specks
□ Glaucoma
□ Cataracts

Nose –
□ Stuffiness
□ Discharge
□ Itching
□ Hay Fever
□ Nose Bleeds
□ Sinus Pain

Neck –
□ Lumps
□ Swollen Glands
□ Pain
□ Stiffness

Respiratory –
□ Cough
□ Sputum
□ Coughing up Blood
□ Shortness of Breath
□ Wheezing
□ Painful Breathing

Cardiovascular –
□ Chest Pain or Discomfort
□ Tightness
□ Palpitations
□ Shortness of Breath with Activity
□ Difficulty Breathing while Lying Down
□ Sudden Awakening from Sleep with Shortness of Breath

Gastrointestinal –
□ Swallowing Difficulties
□ Heartburn
□ Nausea
□ Change in Bowel Habits
□ Rectal Bleeding
□ Diarrhea
□ Yellows Eyes or Skin

Hematologic –
□ Ease of Bruising
□ Ease of Bleeding

Urinary –
□ Frequency
□ Urgency
□ Burning or Pain
□ Blood in Urine
□ Change in Urinary Strength

Vascular –
□ Calf Pain with Walking
□ Leg Cramping

Musculoskeletal –
□ Muscle of Joint Pain
□ Stiffness
□ Back Pain
□ Redness of Joints
□ Swelling of Joints
□ Trauma

Neurologic –
□ Dizziness
□ Fainting
□ Swelling
□ Seizures
□ Weakness
□ Numbness
□ Tingling
□ Tremor

Endocrine –
□ Head or Cold Intolerance
□ Sweating
□ Thirst

Psychiatric –
□ Nervousness
□ Stress
□ Depression
□ Memory Loss