NEW PATIENT MEDICAL HISTORY PACKET

First Name: ________________ Last Name: ____________________ Birth Date: __________ Gender: **Male** **Female**

Height: _________ Weight__________ Primary Care Physician: ____________________ City/State: ___________________

Referring Physician: ______________________________________ City, State: ______________________________

Current Pharmacy: ______________________________________ Street & City: _____________________________

Brief reason for visit and explanation of your pain:

____

____

____

1. **Allergies** – Please list all medication or latex allergies.

Allergy:	Reaction:
Allergy:	Reaction:
Allergy:	Reaction:
Allergy:	Reaction:
Allergy:	Reaction:
Allergy:	Reaction:

2. **Past Medical History**- Circle ANY of the problems **YOU** have had

High Blood Pressure	Diabetes	Hypoglycemia	Heart Disease
Measles/Mumps/Rubella	Heart Attack	Asthma	Bronchitis/ Emphysema
Tuberculosis	Stomach Ulcer	Glaucoma	Migraines/Headache
Muscle Disease	Tissue Disease	Seizure	Stroke
Depression	Cancer	Arthritis	Polio
Constipation	Prostate Problems	Kidney Trouble	Swelling of Joints
Thyroid Disease	Bleeding Disorder	HIV/AIDS	Hepatitis
Taking Blood thinner	Other:__________________________		

3. **Family History**- Circle ANY of the problems BLOOD relatives have had

Diabetes	Tuberculosis	Heart Disease	Vascular Disease
Fibromyalgia	Chronic Pain	Psychiatric Problems	Stroke
Drug Addiction	Lupus	Rheumatoid Arthritis	Cancer

4. **Social History:**

Marital Status: Single Married Widowed Divorced Separated

Do you SMOKE: Yes No If yes, pack per day? _________

Do you drink: Yes No How often? Daily Weekly Occasionally Socially

Do you or have you use street drugs? Currently Past If Yes, then when________________
Circle any that apply: Marijuana Cocaine Amphetamine Heroin

Have you ever participated in a rehabilitation program for alcohol or substance abuse? Yes No
If so, for what substance? ____

Are you working? Yes No How many hours daily? 1 2 3 4 5 6 7 8 9 10+
Do you receive disability? Yes No
Do you plan to return to work soon? Yes No
Are you involved in a lawsuit related to your pain condition? Yes No
Are your visits WORKMANS COMP claims? Yes No

5. **Mental History:**
Do you currently take medications for mental health reasons? Yes No
Have you or do you currently see a psychiatrist or counselor? Yes No
Have you ever been counseled/treated for addiction? Yes No

6. **Sexual History:**
Are you sexually active? Yes No
Does your pain medication regimen affect your sexual relationship? Yes No
Do you experience pain during intercourse? Yes No

7. **Past Surgical History:** Please List Surgeries, Dates, and Physicians

	Date:	Doctor:
1.	Date:	Doctor:
2.	Date:	Doctor:
3.	Date:	Doctor:
4.	Date:	Doctor:
5.	Date:	Doctor:
6.	Date:	Doctor:

8. **CURRENT MEDICATIONS**: (use back of page if needed)

Medication	Dose (mg)	How often a day?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

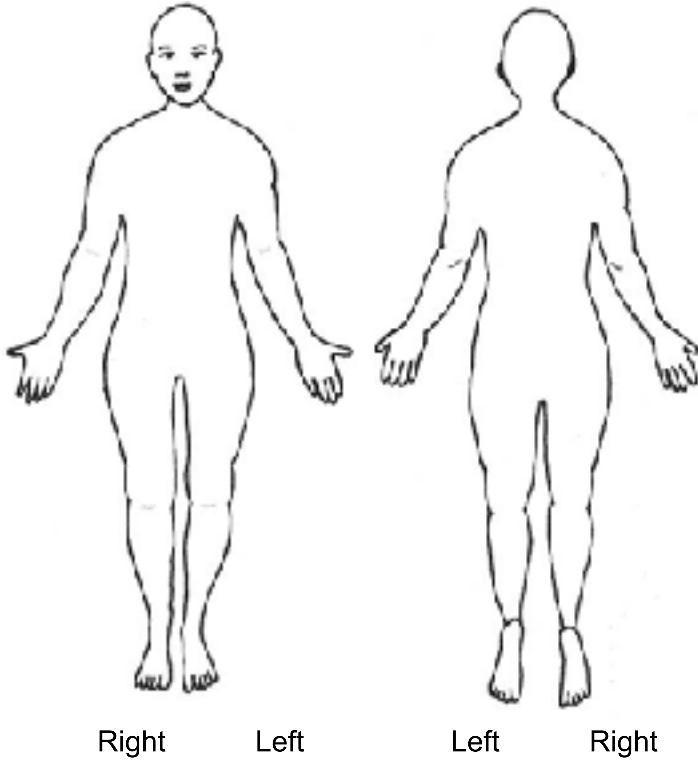
9. **Onset:** When did your pain/problem start? (Time frame/year)

____
____

10. **Location/Duration:** Describe where your pain is located and how long have you have had this pain?

____
____
____

**<u>Shade areas of Pain</u>



11. **<u>Frequency of Pain:</u> Circle ANY of the following that describe your pain**

Continuous   Brief   Sporadic   Rare   Constant with Flares

12. **<u>Pain Quality:</u> Circle ANY symptoms that describe your pain**

Aching	Burning	Cramping	Deep	Dull	Numbness
Penetrating	Pins & Needles	Pulling	Sharp	Shooting	Stabbing
Spreading	Tender	Tingling	Throbbing		

13. Circle **any** area that describes where the **Pain Radiates**

Pain does not Radiate		Right Upper Extremity		Left Upper Extremity	
Back Side of Both Thighs		Bilateral Lower Extremity		Bilateral Upper Extremities	
Right Lower Extremity		Left Lower Extremity		Right Hand	Left Hand
Right Foot	Left Foot	Right Knee	Left Knee	Right Hip	Left Hip

14. **Pain Level:** (Scale of 0-10, No pain 0 - Worst pain 10)

Worst Pain_________ Least Pain___________
Average Pain_______ Current Pain _________

15. **Worsening Factors:** Circle ANY factor that worsens your pain

Bending	Cold/Rainy Weather	Coughing	Getting up from sitting/lying position	
Housework	Increased Activity	Lifting	Looking Up	Looking Down
Lying Flat on Back	Lying Flat on Stomach	Sitting	Standing	Twisting
Walking	Sometimes No Reason			

16. **Relieving Factors:** Circle ALL that make your pain better

Changing Position	Cold Pack	Exercise	Heating Pad	Injections	Lying Down
Lying Flat	Massage	Medications	Rest	Sitting	Standing
Walking	Sometimes Nothing Helps				

17. **Associated Symptoms:** Circle ALL symptoms you have when you are in pain

Depression	Dependence for others on activities	Difficulty carrying out certain activities	
Difficulty staying asleep due to pain	Falling	Frustration	Numbness
Recent fever, chills, or sweats	Weakness		

18. Do you have side effects from current medications? Yes No If so, List: _______________

19. **Treatment History:** Circle all Caregivers you have visited

Pain Medicine Physician	Family Physician	Spine Surgeon	Neurologist
Physical Therapist	Chiropractor	Orthopedist	Psychiatrist
General Surgeon	Endocrinologist	Neurologist	Rheumatologist

20. **Previous Tests Performed:** Circle all that apply

MRI	CT Scan	X-Rays	EMG Test	Discogram	Myelogram
Bone Scan	EEG	EKG	Thyroid Panel	HIV/Aids Test	Ultrasound
Hepatitis Antibody		No Testing			

21. **<u>Please Circle ANY medications below that you have taken in the past regarding your pain:</u>**

NSAID'S-Ibuprofen, Aspirin, Naproxen, Motrin, Advil, Tylenol	Celebrex	Skelaxin	Soma	Robaxin		
Flexeril	Zanaflex	Diclofenac/Mobic/Flector patches	Baclofen	Gabapentin	Horizant	
Lyrica	Amitriptyline	Topamax	Relpax	Depakote	Wellbutrin	Zoloft
Paxil	Prozac	Cymbalta	Savella	Tizanadine	Fioricet/Fiorinal	Imitrex
Ultram/Tramadol	Hydrocodone	Oxycdodone	Fentanyl Patches	Hydromorphone		
Oxycontin	MS-Contin	Morphine	Nucynta	Opana	Methadone	Ketamine
Butrans Patches	Stadol	Medrol Dose Pack/Steroid Pack	Colace/Dulcolax/Miralax			

22. **<u>Please Circle ALL treatments you have received</u>**

Acupuncture	Chemical Denervation	Discography	Epidural Blood Patch	Trigger Point
Epidural Steroid Injection	Facet Injection	Nerve Block	Home Exercises	
Occipital Nerve Block	RadioFrequency Ablation	Sacroiliac Joint Injection	Spinal Cord Stimulation	
TENS Unit	Heat	Ice	Massage	Surgery

23. **Please answer the following questions as honestly as possible, there are no wrong answers.**

SOAAP-R	Never	Seldom	Sometimes	Often	Very Often
How often do you have mood swings?	*	*	*	*	*
How often have you felt a need for higher doses of medication to treat your pain?	*	*	*	*	*
How often have you felt impatient with your doctors?	*	*	*	*	*
How often have you felt that things are just too overwhelming that you can't handle them?	*	*	*	*	*
How often is there tension at home?	*	*	*	*	*
How often have you been concerned that people will judge you for taking pain medication?	*	*	*	*	*
How often do you count pain pills to see how many are remaining?	*	*	*	*	*
How often do you feel bored?	*	*	*	*	*
How often have you taken more pain medication that you were supposed to?	*	*	*	*	*
How often have you worried about being left alone?	*	*	*	*	*
How often have you felt a craving for medication?	*	*	*	*	*
How often have others expressed concern over your use of medication?	*	*	*	*	*
How often have any of your close friends had a problem with drugs/alcohol?	*	*	*	*	*
How often have others told you that you had a bad temper?	*	*	*	*	*
How often have you felt consumed by the need to get pain medication?	*	*	*	*	*

How often do you run out of pain medication?	*	*	*	*	*
How often have others kept you from getting what you deserve?	*	*	*	*	*
How often, in your lifetime, have you had legal problems or been arrested?	*	*	*	*	*
How often have you attended an AA or NA meeting	*	*	*	*	*
How often have you been in an argument that was so out of control that someone got hurt?	*	*	*	*	*
How often have you been sexually abused?	*	*	*	*	*
How often have others suggested that you have a drug or alcohol problem?	*	*	*	*	*
How often have you had to borrow pain medications from family or friends?	*	*	*	*	*

24. **Review of Symptoms:** Circle **ANY** of the symptoms you have had **RECENTLY**

Cardiovascular:	Chest Pain Irregular Heartbeat Shortness of Breath Palpitations Limb pain Feet Swelling
Constitutional Symptoms:	Fever Weight Gain Weight Loss Poor Appetite Sleep Difficulty Tiredness
Endocrine:	Excessive Thirst Heat or Cold Intolerance Erectile Dysfunction Thyroid Trouble Loss of Sexual Desire
Eyes:	Blurred Vision Double Vision Eye Pain
Gastrointestinal:	Abdominal Pain Nausea Vomiting Diarrhea Constipation
Genitourinary:	Urinary Incontinence Pain during Urination Kidney Stones Difficulty
HEENT:	Dizziness Hoarseness Ear Pain
Hematologic:	Abnormal Bleeding Bleeding Disorder Easy Bruising
Musculoskeletal:	Muscle Cramp Neck Pain Loss of Bulk Muscle Back Pain Joint Pain Joint Stiffness Joint Swelling Arthritis Limitation of Joint Movement Muscle Tenderness
Neurological:	Headache Numbness Arm Numbness Leg Numbness Tremors Trouble with Memory Trouble Concentration Unsteady Walk Stroke Epilepsy/Seizures Sedation Spasticity
Psychological:	Depression Anxiety Panic Attack Suicidal Ideation
Respiratory:	Trouble Breathing Snoring Trouble Breathing during sleep Cough Wheezing Congestion
Skin	Rashes Ulcers Infection Color Changes Hypersensitivity

25. **PQRS:** Please circle an answer for **EACH** question

Do You have an Advanced Care Plan on File with PTCOA?	**YES**	**NO**
Do You have a Surrogate Decision Maker?	**YES**	**NO**
Have you fallen within the last year?	**YES**	**NO How many times? ______**
Have you received an Influenza Vaccine this year?	**YES**	**NO**
Do you currently smoke?	**YES**	**NO**
Are you being treated for High Blood Pressure?	**YES**	**NO**
Have you received a Pneumonia Vaccine this year?	**YES**	**NO**