

Center for Pain Management Health History

Patient Name: _____ **Date:** _____

Referring Physician Name: _____ **Birth Date:** _____

Allergies: (Please list allergies to any medications, foods, x-ray, dye, etc and give type of reaction).

Medication

Reaction

MEDICATION LIST

1.	
2.	
3.	
4.	
5.	

6.	
7.	
8.	
9.	
10.	

ILLNESSES

Please note if you have, or had any of the following:

- | | | | | | |
|--|-------|--|------|---|------|
| <input type="checkbox"/> Sugar diabetes | 19__ | <input type="checkbox"/> Asthma | 19__ | <input type="checkbox"/> Degenerative joint disease | 19__ |
| <input type="checkbox"/> Kidney stones | 19__ | <input type="checkbox"/> Hepatitis | 19__ | <input type="checkbox"/> Heart disease | 19__ |
| <input type="checkbox"/> Osteoporosis | 19__ | <input type="checkbox"/> High blood pressure | 19__ | <input type="checkbox"/> Prostate problems | 19__ |
| <input type="checkbox"/> Emphysema | 19__ | <input type="checkbox"/> Thyroid disease | 19__ | <input type="checkbox"/> Bladder problems | 19__ |
| <input type="checkbox"/> Other major illness | _____ | | 19__ | | |

SURGERIES:

1.	
2.	
3.	
4.	
5.	

6.	
7.	
8.	
9.	
10.	

FAMILY HISTORY Living/Deceased

<p>Health (please enter correct letter to correspond with their health along and list any health problems they had/have) G–Good, F-Fair, P-Poor U-Unknown, D-Deceased (list cause of death)</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 15%; text-align: center;">Age</th> <th style="width: 70%; text-align: center;">Condition/Health Problems</th> </tr> </thead> <tbody> <tr><td>Father</td><td></td><td></td></tr> <tr><td>Mother</td><td></td><td></td></tr> <tr><td>Brother/Sister</td><td></td><td></td></tr> <tr><td> </td><td></td><td></td></tr> <tr><td> </td><td></td><td></td></tr> <tr><td> </td><td></td><td></td></tr> <tr><td>Spouse</td><td></td><td></td></tr> <tr><td>Children</td><td></td><td></td></tr> <tr><td> </td><td></td><td></td></tr> <tr><td> </td><td></td><td></td></tr> </tbody> </table> <p>Family History Unknown Patient Adopted <input type="checkbox"/></p>		Age	Condition/Health Problems	Father			Mother			Brother/Sister												Spouse			Children									<p>Has any blood relative had any of the Following and list who.</p> <table style="width: 100%; border-collapse: collapse;"> <tr><td>Cancer</td><td>Yes/No</td><td>_____</td></tr> <tr><td>Tuberculosis</td><td>Yes/No</td><td>_____</td></tr> <tr><td>Diabetes</td><td>Yes/No</td><td>_____</td></tr> <tr><td>Stroke</td><td>Yes/No</td><td>_____</td></tr> <tr><td>Thyroid disease</td><td>Yes/No</td><td>_____</td></tr> <tr><td>Bowel disease</td><td>Yes/No</td><td>_____</td></tr> <tr><td>Ulcers</td><td>Yes/No</td><td>_____</td></tr> <tr><td>Kidney disease</td><td>Yes/No</td><td>_____</td></tr> <tr><td>Heart disease</td><td>Yes/No</td><td>_____</td></tr> <tr><td>Heart attack</td><td>Yes/No</td><td>_____</td></tr> </table>	Cancer	Yes/No	_____	Tuberculosis	Yes/No	_____	Diabetes	Yes/No	_____	Stroke	Yes/No	_____	Thyroid disease	Yes/No	_____	Bowel disease	Yes/No	_____	Ulcers	Yes/No	_____	Kidney disease	Yes/No	_____	Heart disease	Yes/No	_____	Heart attack	Yes/No	_____
	Age	Condition/Health Problems																																																														
Father																																																																
Mother																																																																
Brother/Sister																																																																
Spouse																																																																
Children																																																																
Cancer	Yes/No	_____																																																														
Tuberculosis	Yes/No	_____																																																														
Diabetes	Yes/No	_____																																																														
Stroke	Yes/No	_____																																																														
Thyroid disease	Yes/No	_____																																																														
Bowel disease	Yes/No	_____																																																														
Ulcers	Yes/No	_____																																																														
Kidney disease	Yes/No	_____																																																														
Heart disease	Yes/No	_____																																																														
Heart attack	Yes/No	_____																																																														

Review of Symptoms

	Yes	No
1. Having pain now	_____	_____
2. Pain within past 24 hours	_____	_____
3. Type of pain:		
Burning	_____	_____
Sharp	_____	_____
Aching	_____	_____
Throbbing	_____	_____
Shooting	_____	_____
Numbness/Tingling	_____	_____
4. Rate your pain on a scale from 0 to 10		
0 being no pain and 10 being worst pain _____		
5. When did your pain start? _____		
6. At what time in a 24 hour day is the pain the worst? _____		
7. What makes the pain better? _____		
8. What makes the pain worse? _____		
9. Estimate your ability to cope with pain on scale of 0 to 10		
0 unable to cope and 10 able to cope _____		
10. Are you able to perform daily activities?	_____	_____
11. Fever, chill, nightsweats	_____	_____
12. Weight gain or loss	_____	_____
13. Difficulty falling or staying asleep	_____	_____
14. Fatigue, lack of energy	_____	_____
15. Double vision, dry eyes	_____	_____
16. Glaucoma, cataracts	_____	_____
17. Headaches	_____	_____
18. Deafness, ringing in ears	_____	_____
19. Sinus troubles, nosebleeds	_____	_____
20. Chest pain or discomfort	_____	_____
21. Palpitations irregular heart beat	_____	_____
22. Swelling ankles, hands	_____	_____
23. Shortness of breath – rest, activity	_____	_____
24. Wheezing or cough	_____	_____
25. Difficulty swallowing, heart burn	_____	_____
26. Pain stomach	_____	_____
27. Nausea, vomiting	_____	_____
28. Poor appetite	_____	_____
29. Diarrhea or constipation	_____	_____
30. Difficulties or pain with urination (burning)	_____	_____
31. Joint pain, swelling or stiffness	_____	_____
32. Skin rash or itching	_____	_____
33. Hands change color when cold	_____	_____
34. Tremor, seizures, or black outs	_____	_____
35. Depression or anxiety	_____	_____
36. Heat or cold intolerance	_____	_____
37. Unusual bleeding or bruising	_____	_____
38. Other _____	_____	_____
39. Is there any chance you might be pregnant?	_____	_____
40. Last menstrual period _____		
41. Sexual dysfunctions	_____	_____

SOCIAL HISTORY

SUBSTANCE USE:	Quantity	
Coffee		Cups per day
Tea		Cups per day
Beer		Per day/ per week
Alcoholic Beverages		Per day/ per week
Tobacco Use		Per Day