

Centers for Pain Management New Patient History and Questionnaire

Patient Name:			
Date of Birth:/			
Primary Care Physician:	Phone:(_)	
Who referred you to us?	Phone:(_)	
Reason for today's visit?			
Is this due to an injury? Yes No If yes, what was the date and place of injury? Area of injury Was this a motor vehicle accident? Yes No			
Was this a motor vehicle accident? Yes No Work related injury? Yes No Is this a Workman's Compensation claim? Yes	No		
Do you currently have an attorney? Yes No If yes, what is their name			
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Your Medical History (please check	all that appl	<u>y)</u>	
Asthma Yes No High Blood Pressure Yes No Stroke Yes No Seizures/Convulsions Yes No Scoliosis Yes No Bleeding Disorder Yes No Stomach ulcers Yes No Thyroid Disorder Yes No Arthritis Yes No Mental Illness Yes No Heart Disease Yes No Rheumatoid Arthritis Yes No Diabetes Yes No Type I Type II			

Cancer Type	
Are you pregnant? NoYes	If yes, how many weeks?
Do you have any medical conditions	that affect your bones or joints?
Please list ALL medications that yo	ou are taking including over the counter medications.
Name:	Name:
Strength:	Strength:
How often:	How often:
Name:	Name:
Strength:	Strength:
How often:	How often:
Name:	Name:
Strength:	Strength:
How often:	How often:
Name:	Name:
Strength:	Strength:
How often:	How often:
Name:	Name:
Strength:	Strength:
How often:	How often:
Name:	Name:
Strength:	Strength:
How often:	How often:

Family History

Family Member	Age	Illness	Deceased?	Cause
Mother				
Father				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Son				
Son				
Daughter				
Daughter				
Type?	history of arthritis'	Who?e, addiction or abu		
_	history of alcohol a		? NoYes	-

Have you ever been told you are allergic to LATEX? No ___Yes ___

If yes, who told you and under what circumstances?____

<u>List All Surgeries</u>
Date
Data
Date
Patient Information Do you have a history of Drug use, addiction or abuse? No Yes If yes, to what?
Do you have a history of alcohol abuse or addiction? No Yes Do you currently drink alcohol? No Yes If yes what kind, how much and how often?
Do you use tobacco? No Yes Smokeless tobacco _ Cigar _ Snuff If you smoke cigarettes, how many packs per day? Less than 1 1 2 3 more than 3 per day
Marital status? Single (never been married) Married Divorced Widowed Separated
Current living situation: Alone Spouse Family Friend Assisted Living Facility
Are You? Right handed Both
Hobbies/Sports?
Are you currently working? NoYes Type work

Retired? No Yes
Type work
Have you ever been seen by another pain specialist? No Yes
Who?Where?
Is there a reason you no longer see them?
Have you had a recent weight loss? YesNo
If yes, How much? How long?
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Have you had a recent weight gain? YesNo
If yes, How much? How long?
Do you have sleep apnea? Yes No
Do you use a breathing machine? No Yes
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Have you had good general health lately? Yes No
If no, why?
Do you have visual problems? Yes No
If yes, what?
Do you wear glasses? Yes No Contacts? Yes No
Have you ever been told you have Hepatitis? Yes No
If yes, what type?
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Do you have dizziness? Yes No Paralysis? Yes No
Where?
Do you have singing in the case? Was No. Haging Logs? Was No.
Do you have ringing in the ears? Yes No Hearing Loss? Yes No Do you wear a hearing aid(s)? Yes No Right Left Both
Do you wear a nearing aid(s)? TesNo Right Left Both
Have you ever had a blood transfusion? Yes No
When?
Have you ever been exposed to HIV? Yes No
When?

Please list all Phy year.	sicians you are cu	rrently seeing or have	e seen in the last
Physician Name	Address	City,State	Phone
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Physician Name	Address	City,State	Phone
			()
Physician Name	Address	City,State	Phone
			()
Physician Name	Address	City,State	Phone
			()
Physician Name	Address	City,State	Phone
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