FLORIDA PAIN MEDICINE
Restore Function Relive Life
INTERVENTIONAL SPINE & PAIN MANAGEMENT

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name: *Last* *First* *MI*

Today's Date: **Reason for Visit:**

Previous or referring doctor: **Patient sex :** ☐ M ☐ F **DOB:**

REASON FOR VISIT (MAIN REASON FOR DOCTOR'S APPOINTMENT): _____

HISTORY OF PRESENT PAIN PROBLEM

DATE OF ONSET:_____ **HOW DID IT START?** _____

WHAT MAKES THE PAIN WORSE? ☐ Sitting ☐ Standing ☐ Lying Flat ☐ Walking ☐ Twisting ☐ Exercise ☐ Sneezing ☐ Work ☐ Meds ☐ Other _____

WHAT MAKES THE PAIN BETTER? ☐ Sitting ☐ Standing ☐ Lying Flat ☐ Walking ☐ Twisting ☐ Exercise ☐ Sneezing ☐ Work ☐ Meds ☐ Other _____

DESCRIBE YOUR PAIN: _____

IS THIS RELATED TO AN AUTO INJURY? ☐ Yes ☐ No **IS THERE A LEGAL CASE/LITIGATION?** ☐ Yes ☐ No

IS THIS A WORKMAN'S COMPENSATION CASE? ☐ Yes ☐ No

PAIN (CHECK ONE): ☐ Continuous ☐ Intermitent (Comes and goes) **How long does it last?** _____

HOW MANY TIMES PER DAY DO YOU EXPERIENCE THIS PAIN? RATE THE LEVEL OF PAIN AT PRESENT:

☐ No pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

RATE YOUR PAIN WITH ACTIVITY: ☐ No Pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

CHECK THE WORDS THAT DESCRIBE YOUR PAIN AND INDICATE THE AREA WHERE YOUR PAIN IS WORSE AND SECOND:

☐ Aching - Worst_____ Second_____
☐ Burning - Worst_____ Second_____
☐ Dull - Worst_____ Second_____
☐ Deep - Worst_____ Second_____
☐ Electrical -- Worst_____ Second_____
☐ Sharp - Worst_____ Second_____
☐ Radiating - Worst_____ Second_____
☐ Shooting - Worst_____ Second_____
☐ Tender - Worst_____ Second_____
☐ Stabbing - Worst_____ Second_____
☐ Throbbing - Worst_____ Second_____
☐ Tingling - Worst_____ Second _____

DOES YOUR PAIN INTERFERE WITH YOUR SLEEP? ☐ Yes ☐ No

HOW MANY WORK DAYS DID YOU MISS IN THE LAST MONTH DUE TO PAIN?

PLEASE LIST OTHER PHYSICIANS YOU HAVE SEEN FOR PAIN:

NAME:_____ **RECOMMENDATION:**_____ **SPECIALTY:**_____ **DATE:**_____
NAME:_____ **RECOMMENDATION:**_____ **SPECIALTY:**_____ **DATE:**_____
NAME:_____ **RECOMMENDATION:** _____ **SPECIALTY:**_____ **DATE:**_____

PLEASE CHECK ANY OF THE FOLLOWING TREATMENTS YOU HAVE HAD FOR PAIN:

☐ Pain Clinic – Pain Improved? ☐ Yes ☐ No
☐ Nerve Blocks – Pain Improved? ☐ Yes ☐ No
☐ Epidurals – Pain Improved? ☐ Yes ☐ No
☐ Radio-Frequency – Pain Improved? ☐ Yes ☐ No
☐ Spinal Cord Stimulator – Pain Improved? ☐ Yes ☐ No
☐ Pain Pump – Pain Improved? ☐ Yes ☐ No
☐ Tens Unit – Pain Improved? ☐ Yes ☐ No
☐ Physical Therapy – Pain Improved? ☐ Yes ☐ No
☐ Accupuncture – Pain Improved? ☐ Yes ☐ No
☐ Chiropractor – Pain Improved? ☐ Yes ☐ No
☐ Massage Therapy – Pain Improved? ☐ Yes ☐ No
☐ Psychology – Pain Improved? ☐ Yes ☐ No
☐ Other _____

WHAT DIAGNOSTIC TESTS/PROCEDURES HAVE YOU HAD FOR THIS PAIN? ☐ MRI Scan ☐ CT Myelogram ☐ X-Ray ☐ EMG/Nerve Study ☐ Discogram ☐ Bone Scan

PERSONAL HEALTH HISTORY (PAST MEDICAL HISTORY)

Conditions you have had in the past (check all that apply):

□ AIDS/HIV +	□ Bulimia	□ Goiter	□ Liver Disease	□ Stroke
□ Alcoholism	□ Cancer	□ Gonorrhea	□ Migraine Headache	□ Suicide Attempt
□ Anemia	□ Cataracts	□ Gout	□ Mononucleosis	□ Thyroid Problems
□ Anorexia	□ Chemical Dependency	□ Heart Disease	□ Multiple Sclerosis	□ TB
□ Arthritis	□ Chicken Pox	□ Hepatitis	□ Pneumonia	□ Ulcers
□ Asthma	□ Diabetes	□ Hernia	□ Polio	LIST ANY OTHERS
□ Bleeding Disorders	□ Emphysema	□ Herpes	□ Prostate Problem	□
□ Breast Lump	□ Epilepsy	□ High Cholesterol	□ Rheumatic Fever	□
□ Bronchitis	□ Glaucoma	□ Kidney Disease	□ Scarlet Fever	□

PATIENT NAME:_____ **DOB:** _____

Surgeries		
Year	**Reason**	**Hospital**

Other hospitalizations		
Year	**Reason**	**Hospital**

Have you ever had a blood transfusion? ☐ **Yes** ☐ **No**

Do you know your blood type? ☐ **Yes** ☐ **No** **Type:** _____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug Name	Strength	Frequency Taken	Drug Name	Strength	Frequency Taken
1			9		
2			10		
3			11		
4			12		
5			13		
6			14		
7			15		
8			16		

Allergies to medications

Drug Name	Reaction You Had	Drug Name	Reaction You Had
1		3	
2		4	

HEALTH HABITS AND PERSONAL SAFETY (SOCIAL HISTORY)

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ **Sedentary (No exercise)** ☐ **Mild exercise (i.e., climb stairs, walk 3 blocks, golf)**			
	☐ **Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)**			
	☐ **Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)**			
Diet	**Are you dieting?** ☐ **Yes** ☐ **No**			
	If yes, are you on a physician prescribed medical diet? ☐ **Yes** ☐ **No**			
	# of meals you eat in an average day?			
Caffeine	☐ **None**	☐ **Coffee**	☐ **Tea**	☐ **Cola**
	# of cups/cans per day?			
Alcohol	**Do you drink alcohol?** ☐ **Yes** ☐ **No** **If yes, what kind?**_____			
	How many drinks per week?			
Tobacco	**Do you use tobacco?** ☐ **Yes** ☐ **No**			
	☐ **Cigarettes – pks./day**	☐ **Chew - #/day**	☐ **Pipe - #/day**	☐ **Cigars - #/day**
	☐ **# of years**	☐ **Or year quit**		

PATIENT NAME:_____ **DOB:** _____

Drugs	**Do you currently use recreational or street drugs?**	☐	**Yes**	☐	**No**
	Have you ever given yourself street drugs with a needle?	☐	**Yes**	☐	**No**
Personal Safety	**Do you live alone?**	☐	**Yes**	☐	**No**
	Do you have frequent falls?	☐	**Yes**	☐	**No**
	Do you have vision or hearing loss?	☐	**Yes**	☐	**No**
	Physical and/or mental abuse have become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your doctor or his staff?	☐	**Yes**	☐	**No**

FAMILY HEALTH HISTORY

Relation	AGE	AGE AT DEATH	SIGNIFICANT HEALTH PROBLEMS
Father			
Mother			
Brothers			
Sisters			

MENTAL HEALTH

Is stress a major problem for you?	☐	**Yes**	☐	**No**
Do you feel depressed?	☐	**Yes**	☐	**No**
Do you panic when stressed?	☐	**Yes**	☐	**No**
Do you have problems with eating or your appetite?	☐	**Yes**	☐	**No**
Do you cry frequently?	☐	**Yes**	☐	**No**
Have you ever seriously thought about hurting yourself?	☐	**Yes**	☐	**No**
Do you have trouble sleeping?	☐	**Yes**	☐	**No**
Have you ever been to a counselor?	☐	**Yes**	☐	**No**

SCREENINGS (please indicate most recent date)

Last Colonoscopy:	☐ **Normal** ☐ **Abnormal**	**Cholesterol Screening:**	☐ **Normal** ☐ **Abnormal**
Test for blood in stools:	☐ **Normal** ☐ **Abnormal**	**Electrocardiogram:**	☐ **Normal** ☐ **Abnormal**

Review Of Systems (check all that apply to you)

CONSTITUTIONAL
- ☐ Change in appetite
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Headache
- ☐ Lightheadedness
- ☐ Sleep Disturbances
- ☐ Weight Gain
- ☐ Weight Loss

ALLERGY/IMMUNO
- ☐ Blistering of Skin
- ☐ Cough
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Sneezing
- ☐ Watery Eyes
- ☐ Wheezing

EYES
- ☐ Blurry vision
- ☐ Diminish Visual Acuity
- ☐ Discharge
- ☐ Dry Eyes
- ☐ Flashes of light
- ☐ Floaters
- ☐ Itching and Redness
- ☐ Pain
- ☐ Red Eye
- ☐ Vision Screen

ENT/MOUTH
- ☐ Blocked Ear(s)
- ☐ Decreased hearing
- ☐ Decreased sense of smell
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Ear Pain
- ☐ Hearing Screen
- ☐ Nosebleed
- ☐ Ringing in Ears
- ☐ Sinus Pain
- ☐ Sore Throat
- ☐ Swollen Glands

ENDOCRINE
- ☐ Cold Intolerance
- ☐ Difficulty Sleeping
- ☐ Dizziness
- ☐ Excessive Sweating
- ☐ Excessive Thirst
- ☐ Frequent Urination
- ☐ Heat Intolerance
- ☐ Irregular Menses
- ☐ Weakness
- ☐ Weight Loss

RESPIRATORY
- ☐ Breathing Pattern
- ☐ Chest Pain
- ☐ Cough
- ☐ Hemoptysis
- ☐ Pain with Inspiration
- ☐ Shortness of breath at rest
- ☐ Shortness of breath with exertion
- ☐ Sputum Production
- Wheezing

CARDIOVASCULAR
- ☐ Chest Pain at rest
- ☐ Chest pain with exertion
- ☐ Claudication
- ☐ Cyanosis
- ☐ Difficulty lying flat
- ☐ Dizziness
- ☐ Dyspnea on exertion
- ☐ Fluid accumulation in legs
- ☐ Irregular heartbeat
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Weakness
- ☐ Weight Gain

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Blood in stool
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Decreased appetite
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Exposure to hepatitis
- ☐ Heartburn
- ☐ Hematemesis
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Vomiting
- ☐ Weight loss

☐ HEMATOLOGY
- ☐ Breast Lump
- ☐ Dizziness
- ☐ Easy bruising
- ☐ Fever
- ☐ Groin Mass
- ☐ Prolonged bleeding
- ☐ Recent transfusion
- ☐ Swollen glands
- ☐ Weakness
- ☐ Weight Loss

GENITOURINARY
- ☐ Abdominal Pain/Swelling
- ☐ Blood in urine
- ☐ Difficulty Urinating
- ☐ Frequent Urination
- ☐ Pain in lower back
- ☐ Painful Urination
- ☐ Bladder incontinence

MUSCULOSKELETAL
- ☐ Carpal tunnel
- ☐ Joint Stiffness
- ☐ Leg cramps
- ☐ Muscle aches
- ☐ Pain in shoulder
- ☐ Painful joints
- ☐ Sciatica
- ☐ Swollen joints
- ☐ Trauma to arm(s)
- ☐ Trauma to hip(s)
- ☐ Trauma to knee(s)
- ☐ Trauma to ankle(s)
- ☐ Weakness

PERIPHERAL VASCULAR
- ☐ Absent pulses in hands
- ☐ Absent pulses in feet
- ☐ Blanching of skin

☐ **Cold extremities** ☐ **Decreased sensation in extremities** ☐ **Pain/cramping in legs after exertion** ☐ **Painful extremities** ☐ **Ulceration of feet** **SKIN** ☐ **Acne** ☐ **Blistering of skin** ☐ **Discoloration** ☐ **Dry skin** ☐ **Eczema** ☐ **Hives**	☐ **Itching** ☐ **Keloid formation** ☐ **Mole(s)** ☐ **Nodule(s)** ☐ **Photosensitivity** ☐ **Rash** ☐ **Rash on feet** ☐ **Scaly lesions of skin/scalp** ☐ **Skin Cancer** ☐ **Skin oozing** ☐ **Sun sensitivity** **NEUROLOGIC** ☐ **Balance Difficulty** ☐ **Coordination**	☐ **Difficulty speaking** ☐ **Dizziness** ☐ **Fainting** ☐ **Gait abnormality** ☐ **Headache** ☐ **Irritability** ☐ **Loss of strength** ☐ **Loss of use of extremity** ☐ **Lower back pain** ☐ **Memory loss** ☐ **Pain** ☐ **Seizures** ☐ **Tics** ☐ **Tingling/Numbness**	☐ **Transient loss of vision** ☐ **Tremor** **PSYCHIATRIC** ☐ **Anxiety** ☐ **Auditory/visual hallucinations** ☐ **Delusions** ☐ **Depressed mood** ☐ **Difficulty sleeping** ☐ **Eating disorder** ☐ **Loss of appetite** ☐ **Mental or physical abuse** ☐ **Stressors** ☐ **Substance Abuse** ☐ **Suicidal thoughts**

THE REMAINDER OF THIS PAGE IS LEFT INTENTIONALLY BLANK

PATIENT NAME:_____ **DOB:** _____

WOMEN ONLY							
Age at menstruation:		**Date of last PAP smear:**	**☐ Normal ☐ Abnormal**				
Number of pregnancies_____Number of live births _____		**Date of or age at last menstruation:**					
Last Mammogram:	**☐ Normal ☐ Abnormal**	**Bone Density Screening:**	**☐ Normal ☐ Abnormal**				
Experienced any recent breast tenderness, lumps, or nipple discharge?				**☐**	**Yes**	**☐**	**No**
Date of last rectal exam?		**☐ Normal ☐ Abnormal**					
MEN ONLY							
Do you usually get up to urinate during the night?				**☐**	**Yes**	**☐**	**No**
If yes, # of times _____							
Do you feel burning discharge from penis?				**☐**	**Yes**	**☐**	**No**
Has the force of your urination decreased?				**☐**	**Yes**	**☐**	**No**
Have you had any kidney, bladder, or prostate infections within the last 12 months?				**☐**	**Yes**	**☐**	**No**
Do you have any problems emptying your bladder completely?				**☐**	**Yes**	**☐**	**No**
Any difficulty with erection or ejaculation?				**☐**	**Yes**	**☐**	**No**
Any testicle pain or swelling?				**☐**	**Yes**	**☐**	**No**
Date of last prostate and rectal exam?		**☐ Normal ☐ Abnormal**					
Date of last PSA test (if any):		**☐ Normal ☐ Abnormal**					

Is there anything else you would like to discuss with the doctor?

_____

_____

_____

_____ _____

Printed Name of Patient or Responsible Party **Relationship to Patient**

_____ _____

Signature of Patient or Responsible Party **Date**

I have reviewed this history with the patient for accuracy and completeness:

_____

Physician signature and date

Patient Name:_____ Date:____/_____/_____

Please answer each question as honestly as possible by putting the corresponding number in the box to the right (ie, if "Seldom" write "1", if "Sometimes" write "2", etc). There are no right or wrong answers.

SCORE	COLOR	Initials of Reviewer

SOAPP®-R

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in your home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					
Has any relative had a problem with: **(Please circle Y/N for each item below)** Alcohol: Y/N Addiction: Y/N Mental Illness: Y/N					

Green = less than 9	***Yellow = 10-21***	***Red = 22 and over***

Please include any additional information you wish about the above answers. Thank you.
STOP: Hand first 6 pages of packet to front desk if filling out paperwork in office