HOUSTON PAIN SPECIALISTS

NEW PATIENT PAIN ASSESSMENT FORM

Patient Name: _____ DOB: _____ Age: _____

Welcome to our office. Our goal is to provide you with the best possible medical care in a timely manner. Please help us by completing this questionnaire:

MEDICAL HISTORY (check all that apply):

_____AIDS
_____Attention Deficit
_____Anemia
_____Anxiety
_____Asthma
_____Bleeding Disorder
_____Cancer: _____
_____Cholesterol – **High/Low**
_____Chronic Back Pain
_____Congestive Heart Failure
_____Coronary Artery Disease
_____Depression
_____Diabetes
_____Diverticulitis
_____Emphysema
_____GI Bleed
_____Gout
_____Heart Attack
_____Hepatitis – **A / B / C**
_____High Blood Pressure
_____HIV
_____**Hyper/Hypo** Thyroid
_____Irregular Heart Beat
_____ Irritable Bowel Syndrome
_____Kidney Failure
_____Liver Problems
_____Lupus
_____Migraines
_____Neurological Disorder
_____Poor Circulation
_____Pulmonary Embolism
_____Reflux
_____Rheumatoid Arthritis
_____Seizures
_____Sexual Dysfunction
_____Skin Rash/Ulcers/Lesions
_____Sleep Apnea
_____Stroke
_____Meningitis
_____**OTHER** _____
_____**NONE**

SURGICAL HISTORY

1. Have you had spinal surgeries? □ CERVICAL (Neck) □ THORACIC (Mid-Back) □ LUMBAR (Low Back)
   If so, what type? _____
2. Have you had Facet/Epidural Steroid Injections? □ CERVICAL(Neck) □ THORACIC(Mid-Back) □ LUMBAR
   If so, last injection date? _____
3. Do you have a **STENT, PACEMAKER, PORT** or any other **implantable device**? □ Yes □ No
   If so, what type? _____

ALL OTHER SURGERIES (check all that apply):

_____Abdominal Surgery
_____Amputation
_____AV Fistula Creation
_____AV Graft
_____Aortic Valve Replacement
_____Appendectomy
_____Beast Surgery
_____Bronchoscopy
_____CABG
_____Carotid Endarterectomy
_____Carpal Tunnel
_____Cataract Extraction
_____Cholecystectomy
_____Colon Resection
_____Craniotomy
_____Gastric Bypass
_____Hemorrhoidectomy
_____Hip Replacement
_____Knee Arthroscopy
_____Knee Replacement
_____Kyphoplasty
_____Lumpectomy
_____Mastectomy
_____Mitral Valve Replacement
_____Nephrectomy Native
_____Para Thyroidectomy
_____Pneumonectomy
_____Prostatectomy
_____PTCA
_____RA-F Bypass
_____Rotator Cuff Repair
_____TURP+
_____TAH w/ BSO
_____Hysterectomy
_____Tonsillectomy
_____Tunneled Dialysis Catheter
_____UPPP
_____Vertebroplasty
_____**OTHER:** _____

Anesthesia Problems: □ Yes □ No
Surgical Complications: □ Yes □ No
Post-OP Complications: □ Yes □ No

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FAMILY HISTORY (check all that apply):

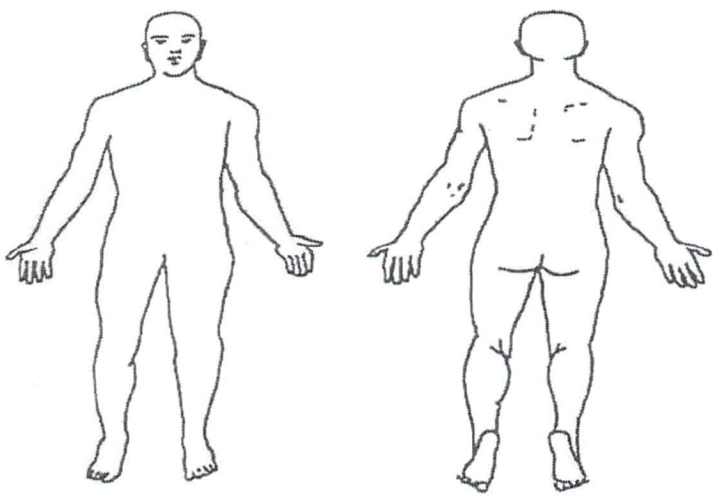
_____Alcoholism
_____Anemia
_____Angina
_____Arthritis
_____Anesthesia Complications
_____Anxiety
_____Asthma
_____Birth Defects
_____Blood Clots
_____Blood Transfusions
_____Bowel Disease
_____Cancer: _____
_____Cholesterol **High/Low**
_____Depression
_____Diabetes
_____Growth Development
_____Headaches
_____Heart Disease
_____Hypertension
_____Liver Disease
_____Melanoma
_____Migraines
_____Osteoporosis
_____Psychiatric Care
_____Seizures
_____Severe Allergies
_____Stroke
_____Suicide Attempt
_____Thyroid Disease
_____Weight Disorder

PAIN HISTORY:

1. What is your chief complaint for todays visit? _____
   _____
2. How did the problem begin?: □ WORK □ INJURY □ MOTOR VEHICLE ACCIDENT □ OTHER
   Brief explanation: _____
3. How often do you have pain and how long does it last?_____
4. Pain is worse WHEN I?_____
5. Pain is better WHEN I?_____
6. Difficulty sleeping? □ YES □ NO
7. Problems with daily activities (personal hygiene, house keeping, walking, grocery shopping, etc)? □ YES □ NO
8. On a scale of 0 to 10 (0=pain free and 10=very painful), pain level right now? _____
9. How would you describe your pain? □ Dull □ Aching □ Throbbing □ Sharp □ Burning
10. Please check below all that applies and write body part:
    □ Numbness - Where? _____
    □ Tingling - Where? _____
    □ Weakness - Where? _____
    □ Coldness - Where? _____
    □ Muscle Spasms/Cramps - Where? _____
    □ Changes on Skin Color - Where? _____

CURRENT PAIN DETAILS

Please use the following symbols to fill in the diagram below:



N = Numbness
\+ = Sharp
* = Burning
Δ = Aching
// = Pins & Needles
• =Shooting
⬭ = Other:_____

Answer the following by circling a number from 0 (no pain) to 10 (worse pain imaginable):

What is your *Current* pain score (0-10):
0 1 2 3 4 5 6 7 8 9 10

What is your *Average* pain score (0-10):
0 1 2 3 4 5 6 7 8 9 10

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PAIN TREATMENT HISTORY:

1. First medical care date for current problem? _____
2. Please list the names of all doctors you have seen for **this** condition:
   - Doctor _____ Specialty_____ Phone _____
   - Doctor _____ Specialty_____ Phone _____
   - Doctor _____ Specialty_____ Phone _____
   - Doctor _____ Specialty_____ Phone _____
   - Doctor _____ Specialty_____ Phone _____
3. What studies were done?
   □ EMG Physician: _____ Most recent date _____
   □ MRI Most recent date _____
   □ CT scan/Myelogram Most recent date _____
   □ X-RAY Most recent date _____
   □ DEXA SCAN Most recent date _____
4. Treatments performed:
   □ Physical Therapy (circle) US, Ten Unit, Massage, Core Strengthening
   □ Exercise Program Relief? _____
   □ Chiropractic Manipulation How long? _____
   □ Injections IN office _____ OutPatient Procedure _____
   □ Psychotherapy/Counseling Results _____
5. **Allergies** to medication? □ No □ Yes - Please List: _____
   _____
6. Allergies other than medications? □ No □ Yes - Please List: _____
7. Please list all of the medications including any over the counter medications, diet supplements, blood thinning medications (Asa, Ecotrin), all herbal (Mai huang, St John's wart), and NSAIDS (Motrin, Ibuprofen, Aleve) medications:

PLEASE LIST ALL INFORMATION REQUESTED

Medication	Doseage	Frequency	Prescribing Physician

- Please be advised, if you have any heart conditions or if you are on Plavix, Coumadin,etc, we will require a written approval from your prescribing physician for discontinuation of these medications prior to scheduling any procedures.
- Please be advised, if you are a diabetic, your blood sugar may increase following steroid injections. Please also note that you need to monitor your blood sugar closely following procedures, and may need assistance at home for 24 hours after injections. Contact your prescribing physcian prior to your procedure for specific instructions.

8. Height _____ Weight _____
9. Have you been **prescribed or use any type of OXYGEN** in the past 12 months? If so, explain usage: _____
10. Have you ever seen a psychologist or psychiatrist? □ Yes □ No

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11. Do you smoke? □ Yes □ No How may cigarettes per day? _____
12. If you are a former smoker, when did you quit? _____
13. Do you drink alcohol? □ Yes □ No
14. Do you use recreational drugs? □ Yes □ No
15. Have you ever had a problem with substance abuse? □ Yes □ No
16. Are you currently working? □ Yes □ No If not, why? _____
17. Please, briefly describe your job duties: _____

Patient Name: _____ DOB: _____

REVIEW OF SYSTEMS (check all that applyto you NOW)

GENERAL	EYES	EARS, NOSE, THROAT	CARDIOVASCULAR	RESPIRATORY
□ fever	□ blurring	□ earache	□ chest pains	□ cough
□ chills	□ diplopia (double vision)	□ ear discharge	□ palpitations	□ dyspnea (difficulty breathing)
□ sweats	□ irritation	□ tinnitus	□ syncope (fainting)	□ excessive sputum
□ anorexia	□ discharge	□ decreased hearing	□ dyspnea on exertion (difficulty breathing)	□ hemoptysis (coughing up blood)
□ fatigue / weakness	□ vision loss	□ nasal congestion	□ orthopnea (difficulty breathing lying flat)	□ wheezing
□ malaise (discomfort)	□ eye pain	□ nosebleeds	□ PND (Paroxysmal Nocturnal Dyspnoea)	□ pleurisy
□ weight loss	□ photophobia	□ sore throat	□ peripheral edema	
□ weight gain		□ hoarseness		
□ sleep disorder				

GASTROINTESTINAL	GENITOURINARY	MUSCULOSKELETAL	DERM / SKIN	NEUROLOGICAL
□ nausea	□ dysuria (painful urinating)	□ back pain	□ rash	□ paralysis
□ vomiting	□ hematuria (blood in urine)	□ neck pain	□ itching	□ paresthesias (burning or prickling in hands, arms, legs, feet, etc)
□ diarrhea	□ discharge	□ joint pain	□ dryness	□ seizures
□ constipation	□ urinary frequency	□ joint swelling	□ suspicious lesions	□ tremors
□ change in bowel habits	□ urinary hesitancy	□ muscle cramps		□ vertigo
□ abdominal pain	□ nocturia (excessive urination at night)	□ muscle weakness		□ transient blindness
□ melena (black, tarry stools)	□ incontinence	□ stiffness		□ frequent falls
□ hematochezia (vomiting of blood)	□ genital sores	□ arthritis		□ frequent headaches
□ jaundice	□ decreased libido	□ sciatica		□ difficulty walking
□ gas / bloating	□ erectile dysfunction	□ restless legs		
□ indigestion / heartburn		□ leg pain at night		
□ dysphagia (difficulty swallowing)		□ leg pain with exertion		
□ odynophagia (painful swallowing)				

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PSYCHOLOGICAL	ENDOCRINE	HEMATOLOGICAL/LYMPHATIC	ALLERGY / IMMUN
□ depression	□ cold intolerance	□ abnormal bruising	□ urticarial (hives)
□ anxiety	□ heat intolerance	□ bleeding	□ allergic rash
□ memory loss	□ polydipsia (excessive thirst)	□ enlarged lymph nodes	□ hay fever
□ suicidal ideation	□ polyphagia (excessive hunger)		□ recurrent infections
□ hallucinations	□ polyuria (excessive amount of urine production)		
□ paranoia	□ unusual weight change		
□ phobia			
□ confusion			

Northwest Anesthesiology and Pain Services, PA