Metro Anesthesia & Pain Management

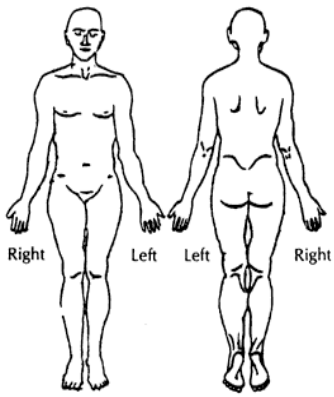
Patient Medical History

NAME_____BIRTH DATE_____AGE _____DATE_____

REFERRING DOCTOR_____FAMILY DOCTOR_____

Where is your pain? _____

Please shade in the affected area



Does your pain radiate to anywhere? _____
_____

When did your pain begin? _____

What caused your pain? (work related, fall, car accident, spontaneous, ect.)
_____

Describe your pain pattern:
constant 75% of the time 50% 25%.

Please rate your pain by circling the one number that best describes your pain at its **WORST** in the last 24 hours:

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the last 24 hours:

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**:

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

Please rate your pain by circling the one number that tells how much pain you have **RIGHT NOW**:

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

Please use the following scale to choose the one number that describes how, in recent time, pain has interfered with your:

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

General Activity_____ Mood_____ Walking Ability_____
Sleep_____ Enjoyment of life_____ Relations with other people_____
Normal Work (includes both work outside the home and housework)_____

Describe your pain: (Circle appropriate response)

burning	throbbing	sharp	dull	shooting	aching	squeezing
stabbing	cramping	penetrating	deep	gnawing		

Aggravating events: (Circle appropriate response)

standing	sitting	lying	walking	sexual activity	bending
eating	heat	cold	coughing	sneezing	twisting
work	stress	other_____			

Please circle all medications that you have tried for this problem:

Anti-inflammatories (Motrin, Aleve, Aspirin, etc.)

Tylenol	Flexeril	Neurontin	Cymbalta	Oxycontin	Morphine	Methadone
Celebrex	Skelaxin	Gralise	Savella	Oxycodone	MsContin	Dilaudid
Voltaren Gel	Zanaflex	Lyrica	Tylenol #3	Percocet	Kadian	Exalgo
Flector Patch	Soma	Topomax	Nubain	Hydrocodone	Avinza	Duragesic/Fentanyl Patch
Pennsaid	Xanax	Tegratol	Demerol	Darvocet	Opana	Butrans Patch
Medrol Dose Pack	Valium Ativan	Amitriptyline Lidoderm Patch	Stadol	Nucynta Ultram/Tramadol	Actiq/Fentora	

Other:_____

Please circle all treatments that you have previously received or are currently receiving for this problem:

Epidural Injection	Physical Therapy	Exercises	Cane or Walker	TENS Unit
Nerve Block/Facet injection	Chiropractor	Relaxation	Brace or Support	
Radiofrequency/Rhizotomy	Acupuncture	Massage	Psychological Treatment	
Trigger Point Injection	Biofeedback	Surgery	Spinal Cord Stimulator/Intrathecal Pump	

Other: _____

What has helped your pain in the past? _____

Previous Testing

X-Ray	MRI	CT Scan	Myelogram	EMG (nerve conduction)
Thermography		Bone Scan	Discogram	Did you bring films today? Yes or No

List all physicians who have treated you for your pain and approximate dates.

_____

_____

Have you been evaluated previously by a pain specialist? Where and when:

_____

_____

Please answer the following questions as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment.

Please use the following scale when answering the following questions:

0=Never, 1=Seldom, 2=Sometimes, 3=Often, 4=Very Often

1. How often do you have mood swings?	0	1	2	3	4
2. How often do you smoke a cigarette within an hour after you wake up?	0	1	2	3	4
3. How often have you taken medication other than the way that it was prescribed?	0	1	2	3	4
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0	1	2	3	4
5. How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4

Past Medical History:

coronary artery disease	heart attack	high blood pressure	emphysema/COPD
hiatal hernia	ulcers	heartburn	asthma
kidney disorder	blood clots	bowel problems	diabetes
liver disorder	hepatitis	HIV	cancer
thyroid disorder	epilepsy	seizures	paralysis
bleeding disorder	stroke	blindness	depression
heart failure	valve problems	glaucoma	anxiety
anemia	arthritis	cataracts	psychiatric disorder
osteoporosis	TB	circulation problems	previous pain

other:_____

Past Surgical History:

Gallbladder	hernia	neck	back
appendectomy	hysterectomy	tonsillectomy	knee
cataract	hip	pacemaker/defibrillator	

other: _____

Medication Allergies: _____

Do you take a blood thinner (Lovenox, Coumadin, Plavix, Aggrenox, Pletal, Effient, Pradaxa, Xarelto, Aspirin…)?

Yes or No

Current Medications:

_____

_____

_____

_____

_____

Who currently prescribes your pain pills? _____

Past Family History: Has any blood relative had any of the following (please circle) and who?
Coronary Artery Disease _____Hypertension _____ Heart Attack _____
Diabetes _____Cancer _____ Stroke _____ Seizures _____
Bleeding Disorders _____ Psychiatric History _____ Alcohol/Substance Abuse _____
Other: _____

Marital status: Married ( ) Single ( ) Divorced ( ) Widowed ( )

List people whom you live with, relationship, and their health

_____

Do you smoke? _____ How much? _____ When did you quit? _____

Do you drink alcohol? (circle) Never socially weekly daily

Do you drink caffeine? _____ How much? _____

Are you currently using any recreational or street drugs? (Circle Yes if used within the past year) Yes or No

Have you ever abused or had an addiction to drugs or alcohol? Yes or No

Have you ever received treatment for drug or alcohol abuse? Yes or No

Current employer: _____ Full-Time _____Part-Time _____Homemaker_____

Complete Review of Systems: Please circle any difficulty or problem you have experienced **within the past month**:

General: Chills, Fever, Night Sweats, Fatigue, Trouble Sleeping, Weight Loss or Gain

Integumentary: New Lesions, Rashes, Itching, Skin Color Changes, Hair and Nail Changes

Head/Eyes/Ears/Nose/Throat: Headache, Visual Disturbances, Vision Loss, Deafness, Decreased Hearing

Respiratory: Shortness of Breath, Cough, Decreased Exercise Tolerance

Cardiac: Chest Pain, Hypertension, Difficulty Breathing Lying Down, Racing Heart, Shortness of Breath, Swelling

Gastrointestinal: Change in Bowel habits, Constipation, Diarrhea, Nausea, Vomiting

Musculoskeletal: Neck Pain, Back Pain, Muscle Spasms, Joint Pain, Muscle Pain

Neurologic: Incontinence Stool, Incontinence Urine, Numbness, Tingling, Weakness

Psychiatric: Anxiety, Depression, Bipolar, Schizophrenia, Suicidal Thoughts, Substance Abuse

Hematologic: Prolonged Bleeding, Spontaneous Bleeding

FOR OFFICE USE ONLY:

Physical Exam

Vitals: BP HR RR WT SOAPP Score

Assessment and Plan

_____

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Dictation conf. #_____