PLEASE INDICATE IF YOU HAVE USED OR TRIED THE FOLLOWING PAIN MEDICATIONS

- ☐ OXYCODONE
- ☐ OXYCONTIN
- ☐ PERCOCET
- ☐ HYDROCODONE
- ☐ MORPHINE IR/ER
- ☐ HYDROMORPHONE (DILAUDID)
- ☐ CYCLOBENZAPRINE (FLEXERIL)
- ☐ OXYMORPHONE (OPANA)
- ☐ CARISOPRODOL (SOMA)
- ☐ METHOCARBAMOL/ROBAXIN
- ☐ BUPRENORPHINE
- ☐ BUTRANS
- ☐ BELBUCA
- ☐ METHADONE
- ☐ SUBOXONE
- ☐ FENTANYL
- ☐ LEVORPHANOL
- ☐ EXALGO (DILAUDID)
- ☐ TAPENTADOL (NUCYNTA)
- ☐ BACLOFEN
- ☐ GABAPENTIN
- ☐ LYRICA
- ☐ AMITRIPTYLINE
- ☐ NORTRIPTYLINE
- ☐ EFFEXOR
- ☐ CYMBALTA
- ☐ IBUPROFEN
- ☐ DICLOFENAC
- ☐ NAPROXEN
- ☐ TYLENOL

PLEASE INDICATE IF YOU HAVE HAD THE FOLLOWING PAST MEDICAL HISTORY OR SURGERIES

CARDIAC:
- ☐ CORONARY ARTERY DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HEART ATTACKS
- ☐ ARRHYTHMIA/PACEMAKER
- ☐ BYPASS SURGERY

ENDOCRINE:
- ☐ DIABETES I
- ☐ DIABETES II
- ☐ HYPOTHYROIDISM
- ☐ HYPERTHYROIDISM
- ☐ ADRENAL INSUFFICIENCY
- ☐ MENOPAUSE

MENTAL HEALTH:
- ☐ DEPRESSION
- ☐ ANXIETY
- ☐ BIPOLAR DISORDER
- ☐ SCHIZOPHRENIA
- ☐ ADHD
- ☐ SUICIDE ATTEMPTS

GASTROINTESTINAL:
- ☐ GERD/ULCERS
- ☐ CROHN'S DISEASE
- ☐ IRRITABLE BOWEL SYNDROME
- ☐ GALLBLADDER DISEASE
- ☐ HEPATITIS A/B/C
- ☐ PANCREATITIS

MUSCULOSKELTAL:
- ☐ FIBROMYALGIA
- ☐ CHRONIC FATIGUE
- ☐ OSTEOARTHRITIS
- ☐ RHEUMATOID ARTHRITIS
- ☐ LUPUS
- ☐ RAYNAUD'S DISEASE

NEUROLOGICAL:
- ☐ MS
- ☐ STROKE
- ☐ MIGRAINE HA
- ☐ TENSION HA
- ☐ SEIZURES
- ☐ POLIO/GUILLAIN-BARRE

PULMONARY:
- ☐ ASTHMA
- ☐ COPD
- ☐ SLEEP APNEA
- ☐ BRONCHITIS
- ☐ PNEUMONIA
- ☐ EMPHYSEMA

ENT:
- ☐ SEASONAL ALLERGIES
- ☐ SINUS INFECTION
- ☐ EAR INFECTION
- ☐ DENTAL PROBLEMS
- ☐ OTHER PROBLEMS:

RENAL:
- ☐ KIDNEY FAILURE
- ☐ KIDNEY STONES
- ☐ INCONTINENCE
- ☐ URINARY TRACT INFECTION

HEMATOLOGI-
- ☐ BLEEDING
- ☐ ANEMIA
- ☐ LEUKEMIA
- ☐ HYPERCOAGUABLE DISORDER

HAVE YOU HAD CANCER? ☐ NO ☐ YES

IF YES, TYPE / COURSE: ____________________

PRIOR SURGERIES: ____________________

FAMILY HISTORY

- ☐ HYPERTENSION
- ☐ HIGH CHOLESTEROL
- ☐ HEART ATTACKS
- ☐ FIBROMYALGIA
- ☐ RHEUMATOID ARTHRITIS
- ☐ BIPOLAR DISORDER
- ☐ STROKE
- ☐ MIGRAINE
- ☐ LUPUS
- ☐ DEPRESSION
- ☐ ANXIETY
- ☐ DIABETES
- ☐ ASTHMA
- ☐ COPD
- ☐ BLEEDING
- ☐ CANCER. IF YES, TYPE/COURSE: ____________________

SOCIAL HISTORY

DO YOU USE OR HAVE YOU USED ANY OF THE FOLLOWING:

- ☐ THC
- ☐ CRACK
- ☐ COCAINE
- ☐ KRATOM
- ☐ HEROIN
- ☐ ECSTASY
- ☐ PCP
- ☐ METHAMPHETAMINE
- ☐ OTHER, IF YES PLEASE EXPLAIN:

DO YOU SMOKE? ☐ YES ☐ NO ☐ QUIT WHEN? ____________

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO ☐ QUIT WHEN? ____________

DO YOU WORK? ☐ YES ☐ NO ☐ RETIRED ☐ DISABLED

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING SYMPTOMS TODAY

CONSTITUTIONAL:
- ☐ FEVERS
- ☐ CHILLS
- ☐ NIGHT SWEATS
- ☐ SLOW HEART RATE
- ☐ EDEMA (SWELLING)
- ☐ WEIGHT GAIN/LOSS
- ☐ OTHER

ENT:
- ☐ HEARING DIFFICULTY
- ☐ VISUAL CHANGES
- ☐ SWALLOWING DIFFICULTY
- ☐ DENTAL PROBLEMS
- ☐ HOARSENESS
- ☐ HEADACHE
- ☐ OTHER

CARDIAC:
- ☐ CHEST PAIN
- ☐ PALPITATIONS
- ☐ FAST HEART RATE
- ☐ SLOW HEART RATE
- ☐ OTHER

NEUROLOGICAL:
- ☐ NUMBNESS/TINGLING
- ☐ SEIZURES
- ☐ MEMORY IMPAIRMENT
- ☐ WEAKNESS
- ☐ INCONTINENCE
- ☐ LOSS OF BALANCE
- ☐ LOSS OF COORDINATION
- ☐ OTHER

MENTAL HEALTH:
- ☐ DEPRESSION
- ☐ ANXIETY
- ☐ SUICIDAL THOUGHTS
- ☐ HOMICIDAL THOUGHTS
- ☐ SLEEP DIFFICULTY
- ☐ RESTLESSNESS
- ☐ CRYING
- ☐ AGITATION
- ☐ INSOMNIA
- ☐ OTHER

PULMONARY:
- ☐ COUGH
- ☐ WHEEZING
- ☐ SHORTNESS OF BREATH
- ☐ OTHER

HEMATOLOGIC:
- ☐ TAKING BLOOD THINNERS
- ☐ EASY BRUISING
- ☐ EXCESSIVE BLEEDING
- ☐ SWOLLEN GLANDS
- ☐ OTHER

MUSCULOSKELETAL:
- ☐ NECK PAIN
- ☐ LOW BACK PAIN
- ☐ MUSCLE PAIN
- ☐ MUSCLE WEAKNESS
- ☐ MORNING STIFFNESS
- ☐ JOINT PAIN
- ☐ JOINT STIFFNESS
- ☐ DIFFICULTY WALKING
- ☐ OTHER

INTEGUMENT:
- ☐ RASH
- ☐ HIVES
- ☐ OTHER

ENDOCRINE:
- ☐ HAIR LOSS
- ☐ EXCESSIVE THIRST
- ☐ OTHER

ENT:
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ NAUSEA/VOMITING
- ☐ ABDOMINAL PAIN
- ☐ JAUNDICE
- ☐ REFLUX
- ☐ OTHER

ARE YOU PREGNANT OR IS THERE A CHANCE YOU MAY BE PREGNANT? ☐ NO ☐ YES ☐ NA