

Patient Health History

Please use blue or black ink only

Patient: _____ Date of Birth: _____ Date: _____

Sex: M F Height: _____ Weight: _____ Handedness: R L

Primary Care Physician: _____ Referring Physician: _____

What problem brought you to our office today?

How long have you had this problem? (Specify date of injury) _____

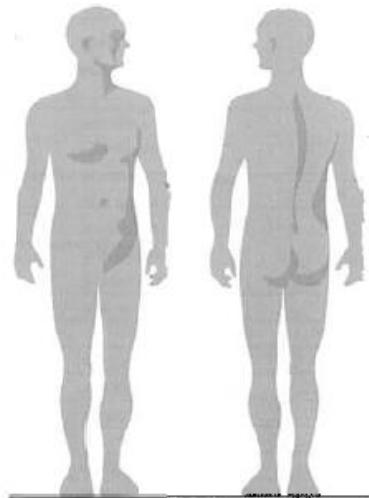
How often does it occur? _____

Is your problem related to work or an auto accident? If so, when? _____

Can you describe your symptoms? (aching, sharp, stabbing, etc.)

What makes your symptoms worse?

What makes your symptoms better?



Circle the area above that is painful
Shade areas of numbness or tingling

Circle the number that best describes your current pain level.

no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

What treatments have you already attempted?

	Effective	Somewhat	Not Effective	Worse	Date
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heat / Ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Diagnostic Studies: What tests have been completed? (List dates)

MRI _____ CT Scan _____ X-rays _____ EMG _____

Office Use Only: Weight: _____ Height: _____ Blood Pressure: _____



PAIN MANAGEMENT

Past Medical History: Please mark any medical problem that you have now or have had in the past.

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Asthma	<input type="checkbox"/> TB
<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Angina	<input type="checkbox"/> Rheumatoid	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Acid Reflux
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Currently pregnant	<input type="checkbox"/> Depression	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Reaction to Anesthesia	

Other psychiatric illness (type): _____

Cancer (type): _____

Other medical illness (describe): _____

Reasons you cannot have an MRI: _____

Medication Allergies: List any medication allergy you have experienced. No Allergies

Name	Reaction	Name	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

Any known allergies to Iodine/ Betadine/ IV Dye: Yes No

Medications: List the medications and dose that you take.

Name	Dosage	How Often	Name	Dosage	How Often
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Family History: Please mark any medical problems that exist in your family.

	Diabetes	High Blood Pressure	Heart Disease	Stroke	Mental Illness	Cancer	Bleeding Disorder	Emphysema/ COPD
Father	<input type="checkbox"/>							
Mother	<input type="checkbox"/>							
Siblings	<input type="checkbox"/>							
Daughter(s)	<input type="checkbox"/>							
Son(s)	<input type="checkbox"/>							
Paternal Grandfather	<input type="checkbox"/>							
Paternal Grandmother	<input type="checkbox"/>							
Maternal Grandfather	<input type="checkbox"/>							
Maternal Grandmother	<input type="checkbox"/>							
Aunt	<input type="checkbox"/>							
Uncle	<input type="checkbox"/>							

Social History:

What is your current marital status? Single Married Divorced Widowed

What is your current occupation? _____

What is your current work status? Fulltime Part Time Limited Duty Unable to Work Without Employment

The last date I worked was: _____ I have been on disability since: _____

Do you smoke tobacco? Yes No How many packs/day? _____ For how long? _____

Do you consume alcohol? Yes No How much? _____ How often? _____

Have you ever had a problem with alcohol in the past? Yes No When? _____

Have you ever used illegal drugs? Yes No When? _____

Have you ever had an addiction problem with narcotic pain medications? Yes No When? _____

Past Surgical History: Please list any surgery you have had in the past with the approximate date.

Your Pharmacy: _____

Review of symptoms for the last six months: Check (✓) the signs/symptoms you are experiencing.

Constitutional:	Cardiovascular/respiratory:	Urinary:	Musculoskeletal	Allergy:
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Chest pain (angina)	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Leg cramps	<input type="checkbox"/> Seasonal
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Swelling	<input type="checkbox"/> Tape
<input type="checkbox"/> Fever	<input type="checkbox"/> Heart arrhythmia	<input type="checkbox"/> Urgency	<input type="checkbox"/> Painful joints	<input type="checkbox"/> Metal
<input type="checkbox"/> Chills	<input type="checkbox"/> Shortness of breath	Neurological:		Head/ears/nose/throat:
<input type="checkbox"/> Sexual dysfunction	Eyes:		<input type="checkbox"/> Muscle loss	<input type="checkbox"/> Headache
Gastrointestinal:		<input type="checkbox"/> Seizure	<input type="checkbox"/> Bruising	<input type="checkbox"/> Hearing loss
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Skin:	<input type="checkbox"/> Nasal drainage
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Double vision	<input type="checkbox"/> Confusion	<input type="checkbox"/> Cancer	
<input type="checkbox"/> Constipation	<input type="checkbox"/> Loss of vision	Psychiatric:		<input type="checkbox"/> Rash
<input type="checkbox"/> Bowel incontinence		<input type="checkbox"/> Depression	<input type="checkbox"/> Ulcer	
<input type="checkbox"/> Blood in stool		<input type="checkbox"/> Mania		
		<input type="checkbox"/> Other		

Which physician(s) is/are treating these conditions? _____

**PEG Scale Assessing Pain Intensity and Interference
(Pain, Enjoyment, General Activity)**

Circle the number that best describes your pain on average in the past week.

no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Circle the number that best describes how pain has interfered with your enjoyment of life in the past week.

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

Circle the number that best describes how pain has interfered with your general activity in the past week.

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

PEG Score: _____

I hereby certify that the above information is correct to the best of my knowledge. I will not hold my physician(s) or any of their staff responsible for any errors or omissions I have made in completing this form.

Signature: _____ Date: _____