



MOUNTAIN STAR

Lakeview Hospital*Pain Management Center***PAIN MANAGEMENT CENTER PATIENT HISTORY**

Name: _____

Please fill in completely (0) all circles (**yes and no**) as pertaining to your current symptoms.**Constitutional**

weight gain	<input type="radio"/> Yes	<input type="radio"/> No
fatigue	<input type="radio"/> Yes	<input type="radio"/> No
fever	<input type="radio"/> Yes	<input type="radio"/> No
loss of appetite	<input type="radio"/> Yes	<input type="radio"/> No

Ophthalmology

drainage from eyes	<input type="radio"/> Yes	<input type="radio"/> No
glasses/contacts	<input type="radio"/> Yes	<input type="radio"/> No
excess tearing	<input type="radio"/> Yes	<input type="radio"/> No
eye pain	<input type="radio"/> Yes	<input type="radio"/> No
vision changes	<input type="radio"/> Yes	<input type="radio"/> No

ENT

ear pain	<input type="radio"/> Yes	<input type="radio"/> No
ear discharge	<input type="radio"/> Yes	<input type="radio"/> No
hearing loss	<input type="radio"/> Yes	<input type="radio"/> No
ringing in ears	<input type="radio"/> Yes	<input type="radio"/> No
ear infection	<input type="radio"/> Yes	<input type="radio"/> No
post-nasal drip	<input type="radio"/> Yes	<input type="radio"/> No
sore throat	<input type="radio"/> Yes	<input type="radio"/> No
bleeding gums	<input type="radio"/> Yes	<input type="radio"/> No

Cardiology

chest pain (angina)	<input type="radio"/> Yes	<input type="radio"/> No
palpitations	<input type="radio"/> Yes	<input type="radio"/> No
heart murmurs	<input type="radio"/> Yes	<input type="radio"/> No
shortness of breath	<input type="radio"/> Yes	<input type="radio"/> No

Respiratory

cough	<input type="radio"/> Yes	<input type="radio"/> No
wheezing	<input type="radio"/> Yes	<input type="radio"/> No
shortness of breath	<input type="radio"/> Yes	<input type="radio"/> No

Gastroenterology

heartburn	<input type="radio"/> Yes	<input type="radio"/> No
peptic ulcers	<input type="radio"/> Yes	<input type="radio"/> No
nausea	<input type="radio"/> Yes	<input type="radio"/> No
vomiting	<input type="radio"/> Yes	<input type="radio"/> No
diarrhea	<input type="radio"/> Yes	<input type="radio"/> No
constipation	<input type="radio"/> Yes	<input type="radio"/> No
laxative use	<input type="radio"/> Yes	<input type="radio"/> No
jaundice	<input type="radio"/> Yes	<input type="radio"/> No
loss of bowel control	<input type="radio"/> Yes	<input type="radio"/> No

Urology

frequent urination	<input type="radio"/> Yes	<input type="radio"/> No
urinary tract infection	<input type="radio"/> Yes	<input type="radio"/> No
painful urination	<input type="radio"/> Yes	<input type="radio"/> No
urinary retention	<input type="radio"/> Yes	<input type="radio"/> No
urinary dribbling	<input type="radio"/> Yes	<input type="radio"/> No
loss of urinary control	<input type="radio"/> Yes	<input type="radio"/> No

Musculoskeletal

joint pain	<input type="radio"/> Yes	<input type="radio"/> No
joint swelling	<input type="radio"/> Yes	<input type="radio"/> No
joint stiffness	<input type="radio"/> Yes	<input type="radio"/> No
muscle cramps	<input type="radio"/> Yes	<input type="radio"/> No
muscle swelling	<input type="radio"/> Yes	<input type="radio"/> No

Neurology

tingling/numbness	<input type="radio"/> Yes	<input type="radio"/> No
fainting	<input type="radio"/> Yes	<input type="radio"/> No
headache	<input type="radio"/> Yes	<input type="radio"/> No
weakness	<input type="radio"/> Yes	<input type="radio"/> No
dizziness	<input type="radio"/> Yes	<input type="radio"/> No

Dermatology

rash	<input type="radio"/> Yes	<input type="radio"/> No
skin itching	<input type="radio"/> Yes	<input type="radio"/> No
skin infection	<input type="radio"/> Yes	<input type="radio"/> No

Endocrinology

hot flashes	<input type="radio"/> Yes	<input type="radio"/> No
hair loss	<input type="radio"/> Yes	<input type="radio"/> No
always hot	<input type="radio"/> Yes	<input type="radio"/> No
always cold	<input type="radio"/> Yes	<input type="radio"/> No
excessive thirst	<input type="radio"/> Yes	<input type="radio"/> No

Hematology/Lymph

easy bruising	<input type="radio"/> Yes	<input type="radio"/> No
easy bleeding	<input type="radio"/> Yes	<input type="radio"/> No
swollen lymph nodes	<input type="radio"/> Yes	<input type="radio"/> No
anemia	<input type="radio"/> Yes	<input type="radio"/> No

Allergy/ Immune system

AIDS	<input type="radio"/> Yes	<input type="radio"/> No
allergies	<input type="radio"/> Yes	<input type="radio"/> No
frequent infections	<input type="radio"/> Yes	<input type="radio"/> No
steroid use	<input type="radio"/> Yes	<input type="radio"/> No
hives	<input type="radio"/> Yes	<input type="radio"/> No

Psychology

anxiety	<input type="radio"/> Yes	<input type="radio"/> No
depression	<input type="radio"/> Yes	<input type="radio"/> No
mood swings	<input type="radio"/> Yes	<input type="radio"/> No
nightmares	<input type="radio"/> Yes	<input type="radio"/> No

Male reproductive

difficulty with erection	<input type="radio"/> Yes	<input type="radio"/> No
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Female reproductive

pregnant	<input type="radio"/> Yes	<input type="radio"/> No
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Where is your pain located?

- | | | | | | |
|---------------------------------|----------------------------------|---------------------------------|-------------------------------|------------------------------|--------------------------------|
| <input type="radio"/> neck | <input type="radio"/> shoulder | <input type="radio"/> upper arm | <input type="radio"/> forearm | <input type="radio"/> finger | <input type="radio"/> low back |
| <input type="radio"/> headaches | <input type="radio"/> thigh | <input type="radio"/> shin | <input type="radio"/> toes | <input type="radio"/> ankle | <input type="radio"/> groin |
| <input type="radio"/> chest | <input type="radio"/> entire arm | <input type="radio"/> axilla | <input type="radio"/> elbow | <input type="radio"/> hand | <input type="radio"/> abdomen |
| <input type="radio"/> ribs | <input type="radio"/> buttock | <input type="radio"/> calf | <input type="radio"/> foot | <input type="radio"/> heel | <input type="radio"/> knee |
| <input type="radio"/> mid-back | <input type="radio"/> facial | | | | |

How long have you had your pain?

- ☐ 0-6 months ☐ 6-12 months ☐ 1-5 years ☐ 5-10 years ☐ longer than 10 years

In the last 2-3 weeks when does your pain occur?

- ☐ intermittent (on/off) ☐ less than 8 hrs/day ☐ 8-16 hrs/day ☐ constant

On a scale of 0 to 10, with 10 being the worst pain, mark where the severity of your pain is.

- ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Associated numbness ☐ Yes ☐ No

Associated Tingling ☐ Yes ☐ No

What was the setting when the problem first occurred?

- | | | |
|---|---|--|
| <input type="radio"/> alcohol consumption | <input type="radio"/> animal bite or sting | <input type="radio"/> infectious disease |
| <input type="radio"/> birth-related conditions | <input type="radio"/> emotional stress | <input type="radio"/> home |
| <input type="radio"/> school or campus | <input type="radio"/> school-related travel | <input type="radio"/> toxic substance exposure |
| <input type="radio"/> prolonged keyboard activity | <input type="radio"/> repetitive grasping | <input type="radio"/> repetitive lifting |
| <input type="radio"/> running/jogging | <input type="radio"/> sports (without obvious trauma) | <input type="radio"/> squatting |
| <input type="radio"/> standing | <input type="radio"/> straining | <input type="radio"/> throwing |
| <input type="radio"/> walking | <input type="radio"/> twisting | <input type="radio"/> weight training |
| <input type="radio"/> underwater diving | <input type="radio"/> stroke (CVA) | <input type="radio"/> surgery |
| <input type="radio"/> reaching | <input type="radio"/> workplace | <input type="radio"/> medication |
| <input type="radio"/> bending over | <input type="radio"/> driving | <input type="radio"/> coughing |
| <input type="radio"/> dancing | <input type="radio"/> having sex | <input type="radio"/> head movement |
| <input type="radio"/> lying down | <input type="radio"/> none identified | <input type="radio"/> sitting |
| <input type="radio"/> sneezing | | |

Please describe your pain (quality): ☐ aching ☐ boring or drilling ☐ cold ☐ crushing
☐ gnawing ☐ hot ☐ nagging ☐ penetrating ☐ pins and needles ☐ pressure
☐ raw ☐ shock-like ☐ shooting ☐ sore ☐ stinging ☐ throbbing
☐ tightness ☐ burning ☐ stabbing ☐ mild ☐ heaviness ☐ dull
☐ moderate ☐ sharp ☐ cramping ☐ severe ☐ other
☐ quality cannot be determined

Please indicate those activities that INCREASE your pain: (check all that apply)

☐ work ☐ walking ☐ bending ☐ lying flat ☐ standing ☐ sitting ☐ stress
☐ alcohol consumption ☐ foods or beverages ☐ locale (i.e. home/work/etc.)
☐ lying on affected side ☐ medications ☐ menstrual cycle
☐ physical activities ☐ recreational drug use ☐ sleep-related factors
☐ toxic substance exposure ☐ travel ☐ underwater diving
☐ weight gain ☐ other

Please indicate those activities that DECREASE your pain: (check all that apply)

☐ walking ☐ standing ☐ rest ☐ applying heat ☐ applying cold ☐ injections
☐ sitting down ☐ physical therapy ☐ relaxation exercises ☐ lying flat ☐ bending
☐ medications ☐ emergency room treatment ☐ elevating the affected area
☐ position change ☐ non weight bearing ☐ supporting the extremity ☐ avoiding stress
☐ massage ☐ moving the area continuously ☐ sleeping ☐ nothing ☐ other

Associated signs/symptoms: ☐ bleeding ☐ bone misalignment ☐ cramping ☐ dizziness
☐ drainage ☐ drop objects ☐ fatigue ☐ fever ☐ joint problems
☐ language difficulty ☐ mental status change ☐ muscle tightness ☐ muscle weakness
☐ nausea ☐ numbness ☐ pain ☐ paralysis ☐ poor sleep ☐ swelling ☐ none

Does your pain affect: ☐ your quality of life ☐ sleep

How many ER visits have you had in the last 3 months for pain?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ more than five ☐ none

Do you take any of the following anticoagulants? (check all that apply)

☐ coumadin ☐ heparin ☐ plavix ☐ fragmin ☐ lovenox ☐ enoxaparin ☐ normiflo
☐ ardeparin ☐ orgaran ☐ danaparoid

Imaging studies in the last 5 years: ☐ CT scan ☐ EMG (electromyogram) ☐ IVP

☐ MRI scan ☐ Myelogram ☐ X-rays ☐ Other tests ☐ None

Have you tried any of these therapies:

☐ acupuncture ☐ biofeedback ☐ chiropractors ☐ elevation ☐ exercise ☐ heat ☐ ice
☐ intradiscal therapy ☐ massage ☐ nerve stimulation ☐ occupational therapy ☐ relaxation
☐ surgery ☐ none

Have you tried any of these pain clinic treatments:

☐ injection therapy ☐ medications
☐ physical therapy ☐ other pain centers ☐ psychotherapy ☐ relaxation ☐ surgery
☐ none

Have you tried the following NSAIDS to help relieve your pain:

☐ ibuprofen ☐ aleve
☐ advil ☐ naproxen ☐ celebrex ☐ toradol ☐ indocin

Are you on Workers Comp? ☐ Yes ☐ No

Mark the appropriate information related to Worker's Compensation:

- ☐ Work related travel ☐ trauma and/or injury ☐ unable to work at all since the injury
☐ able to work with restrictions since the injury ☐ temporary limitations after the injury
☐ no restrictions now ☐ no work restriction since the injury

Litigation Pending: ☐ Yes ☐ No

If you are involved in any lawsuits, who is the lawsuit against? (Check all that apply)

- ☐ Worker's Compensation ☐ Auto Accident ☐ Disability Claim ☐ Other

Have you been to any of the following types of doctors?

- ☐ Back Surgeon ☐ Neurologist ☐ Rheumatologist ☐ Other pain doctor

Past Medical History

- | | | | |
|-------------------|--|----------------------------|--|
| HTN | <input type="radio"/> Yes <input type="radio"/> No | Cancer or Tumor | <input type="radio"/> Yes <input type="radio"/> No |
| Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Anemia/Blood disorder | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis | <input type="radio"/> Yes <input type="radio"/> No | Neurological disorders | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma | <input type="radio"/> Yes <input type="radio"/> No | Bladder/Kidney disease | <input type="radio"/> Yes <input type="radio"/> No |
| Heart disease | <input type="radio"/> Yes <input type="radio"/> No | Liver/gallbladder problems | <input type="radio"/> Yes <input type="radio"/> No |
| Lung disease | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic fever | <input type="radio"/> Yes <input type="radio"/> No |
| Stroke | <input type="radio"/> Yes <input type="radio"/> No | Thyroid/endocrine problem | <input type="radio"/> Yes <input type="radio"/> No |
| Pancreatitis | <input type="radio"/> Yes <input type="radio"/> No | Tension headache | <input type="radio"/> Yes <input type="radio"/> No |
| Bleeding disorder | <input type="radio"/> Yes <input type="radio"/> No | Peptic ulcer disease | <input type="radio"/> Yes <input type="radio"/> No |
| Colitis | <input type="radio"/> Yes <input type="radio"/> No | Autoimmune disorder | <input type="radio"/> Yes <input type="radio"/> No |
| Anxiety disorder | <input type="radio"/> Yes <input type="radio"/> No | Migraine headache | <input type="radio"/> Yes <input type="radio"/> No |
| Seizures | <input type="radio"/> Yes <input type="radio"/> No | | |

Family History

- Is your father still alive? ☐ Yes ☐ No
Is your mother still alive? ☐ Yes ☐ No
Do you have children or other dependents at home? ☐ Yes ☐ No

Social History

- What is your marital status? ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Are you currently employed? ☐ Yes ☐ No
Are you on disability? ☐ Yes ☐ No
What type of disability do you have?
☐ Short term ☐ Long term ☐ Social Security ☐ Other

Do you use alcohol to control your pain? ☐ Yes ☐ No

Mark if you use any of the following drugs recreationally:

- ☐ Amphetamines ☐ Barbituates ☐ Cocaine ☐ Codeine ☐ Diazepam ☐ Heroin
☐ Hydrocodone ☐ Marijuana ☐ Oxycodone ☐ Soma

Dependency or addiction to drugs now or in the past? (Check all that apply)

- ☐ Amphetamines ☐ Barbituates ☐ Cocaine ☐ Codeine ☐ Diazepam ☐ Heroin
☐ Hydrocodone ☐ Marijuana ☐ Morphine ☐ Oxycodone ☐ Soma