Outpatient Services Pain Medicine Questionnaire

Who referred you to Pain Medicine?

_____

Who is your Primary Physician? _____

Have you seen a Pain Management Physician in the past?
If so, who: _____

Date: _____

Height: _____ Weight: _____kg

PAIN EXPERIENCE:

What is your pain problem? _____

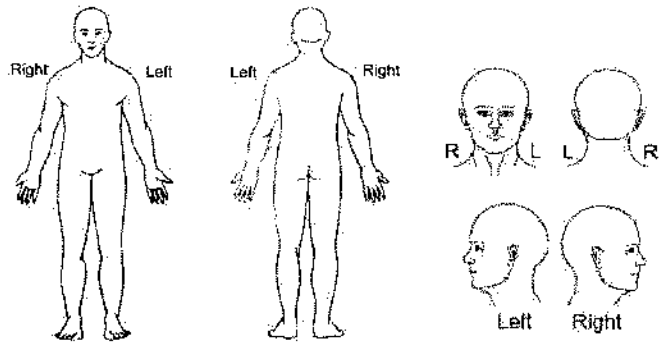
_____

_____

When did the present symptoms start? ____/____/____
month day year

Was the onset: ☐ Gradual ☐ Result of an injury ☐ Surgery
☐ Accident Explain: _____

Mark pain location(s) on diagram(s) below



What makes your pain worse? _____

_____

_____

What eases or reduces your pain? _____

_____

_____

Do you have increased pain when you experience the following?

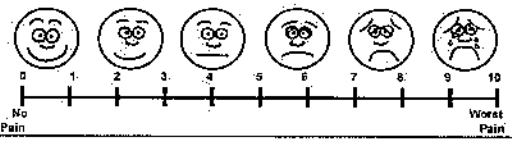
	No	Yes	Location of Pain
Coughing or sneezing	☐	☐	
Bending	☐	☐	
Lifting	☐	☐	
Sitting	☐	☐	
Standing	☐	☐	
Lying Down	☐	☐	
Getting Up or Down	☐	☐	
Walking	☐	☐	

How far can you walk?

Describe your symptoms? (check all that apply)

☐ Constant	☐ Intermittent
☐ Sharp	☐ Dull
☐ Burning	☐ Numbness
☐ Tingling	☐ Loss of Sensation
☐ Throbbing	☐ Aching

In general what is your level of pain?



If it is not possible to completely relieve your pain, what level of pain would be acceptable for you to live with?

No pain — Most Intense Pain

0 1 2 3 4 5 6 7 8 9 10

If you did reach that level of pain relief, what activities would you engage in that your current pain level prevents you from doing?

_____

Since your pain problem began, which of the following treatments have you had? (check all that apply)

	☐	Medications
	☐	Surgery
	☐	Traction
	☐	Physical Therapy
	☐	TENS
	☐	Chiropractic / Osteopathic Manipulation
	☐	Nerve Blocks or injections
	☐	Biofeedback / Relaxation Training
	☐	Counseling / Psychotherapy
	☐	Other:

AdventHealth
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OUTPATIENT SERVICES
PAIN MEDICINE QUESTIONNAIRE
DH: Personal Health History
927-0002 (6/13) MPC #33789

Patient Label

Outpatient Services Pain Medicine Questionnaire

PAST MEDICAL HISTORY

	NO	YES		NO	YES
High Blood Pressure	☐	☐	Gastro-Intestinal Disease	☐	☐
Heart Disease	☐	☐	Cancer	☐	☐
Stroke	☐	☐	HIV / AIDS	☐	☐
Lung Disease / Asthma	☐	☐	Thyroid Disease	☐	☐
Kidney Disease	☐	☐	Phlebitis	☐	☐
Liver Disease/Hepatitis	☐	☐	Bleeding Disorders	☐	☐
Diabetes	☐	☐	Mental Illness	☐	☐
Arthritis	☐	☐	Alcoholism	☐	☐
Neurological Disease	☐	☐	Low Blood Counts/Anemia	☐	☐
Fibromyalgia	☐	☐	Blood Thinners	☐	☐

Other Serious Illnesses or Injuries: _____

ALLERGIES

☐ No Known Allergies

List Any Allergies Below:	Describe the reaction below:
1.	
2.	
3.	
4.	
5.	
6.	

PAST SURGERIES / HOSPITALIZATIONS / ACCIDENTS

☐ None (list any below)

Year	TYPE / REASON:

REVIEW OF SYSTEMS (If no problems exist, check the box in the "No" column)

	No	Check any box below that applies
Head / Eyes / Ears Nose / Throat	☐	☐ Headaches ☐ Glasses ☐ Dizziness ☐ Hearing Aids ☐ Difficulty Swallowing
Neurologic	☐	☐ Seizures ☐ Stroke
Cardiovascular	☐	☐ Chest Pain ☐ Heart Murmur ☐ Abnormal Heart Beat ☐ Hypertension
Pulmonary	☐	☐ Wheezing ☐ Shortness of Breath ☐ Obstructive Sleep Apnea ☐ Tuberculosis
Renal / Genito-Urinary	☐	☐ Dialysis ☐ Kidney Transplant ☐ Impaired Kidney Function ☐ Pelvic Pain ☐ Frequent Urination
Gastro-Intestinal	☐	☐ Abdominal Pain ☐ Nausea / Vomiting ☐ Ulcers ☐ Frequent Constipation ☐ Jaundice ☐ Hepatitis
Emotional Status	☐	☐ Depression ☐ Anxiety ☐ Insomnia ☐ Chronic Fatigue
Musculoskeletal	☐	☐ Fibromyalgia ☐ Shoulder / Neck Pain ☐ Back Pain ☐ Arm Pain ☐ Leg Pain
Endocrine	☐	☐ Excessive Thirst ☐ Hot Flashes
General	☐	☐ Weight Loss ☐ Weight Gain
Skin	☐	☐ Bruise Easily ☐ Rash

Other (list):

SOCIAL HISTORY/ LIFESTYLE HABITS

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Are you currently working? ☐ No ☐ Yes

Occupation: _____

Did you use or do you currently use:	Type	How much / How often	Last time Used
Alcohol ☐ No ☐ Yes			
Tobacco ☐ No ☐ Yes			
Street /recreational drugs ☐ No ☐ Yes			

Who do you live with? ☐ Alone ☐ Spouse ☐ Roommate(s) ☐ Children ☐ Parents ☐ Significant Other

Do you feel afraid or threatened by someone close to you? ☐ No ☐ Yes

Do you have cultural or spiritual customs important to your care or education? ☐ No ☐ Yes, list: _____

How do you learn best? ☐ Seeing ☐ Hearing ☐ Doing

FAMILY HISTORY

Has a family member ever had a chronic illness or a chronic pain problem? ☐ No ☐ If Yes: explain _____

Person providing information: ☐ Patient ☐ Other: _____

Name: _____ Relationship: _____

Reviewed by RN / RN Authentication: _____

RN - Print Name: _____ Date: _____ Time: _____

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