Center for Pain Management Questionnaire • Page 1

Name			Date		
Address			Date of Birth		
City	St	Zip	Age	Wt	Ht
Phone	Cell		Male	Female	

Your Health History

Stroke	Y	N	Alcoholism	Y	N
Heart Trouble	Y	N	Serious Injuries	Y	N
High Blood Pressure	Y	N	Lung Disease	Y	N
Diabetes	Y	N	Tuberculosis	Y	N
Arthritis	Y	N	Phlebitis	Y	N
Gout	Y	N	Anemia	Y	N
Seizures	Y	N	Stomach Trouble	Y	N
Mental Illness	Y	N	Liver Trouble	Y	N
Kidney Trouble/Stones	Y	N	Fibromyalgia	Y	N
Cancer	Y	N	Thyroid Trouble	Y	N
Bleeding Disorders	Y	N	Other Illness	Y	N

Explain all YES Answers

Date	Previous Surgeries (List All)

Current Medications: Prescription AND Non-Prescription

Name	Dose	How Often	Last Dose

Review of Systems

Frequent Headaches	Y	N
Seizures	Y	N
Blackouts	Y	N
Stroke	Y	N
TMJ Disorder	Y	N
Hoarseness	Y	N
Heartburn/Reflux	Y	N
Ulcers	Y	N
Hepatitis/Jaundice	Y	N
Pancreatitis	Y	N
Diabetes	Y	N
Thyroid Disorder	Y	N
Anemia	Y	N
Heart Disease	Y	N
Chest Pains	Y	N
Abnormal Heartbeat	Y	N
Difficulty Breathing	Y	N
Lung Disease	Y	N
Swollen Ankles	Y	N
Frequent Constipation	Y	N
Blood in Stool	Y	N
Leaking of Urine	Y	N
Calf Cramps w/Walking	Y	N
Weight Gain/Loss	Y	N
HIV/AIDS	Y	N
Nervous Tension	Y	N
Insomnia	Y	N
Depression	Y	N

Family History

List any family health problems

Allergies: Medication/Food/Other

None Known	Yes List below
	Reaction:
	Reaction:
	Reaction:
	Reaction:
	Reaction:
	Reaction:

Social History

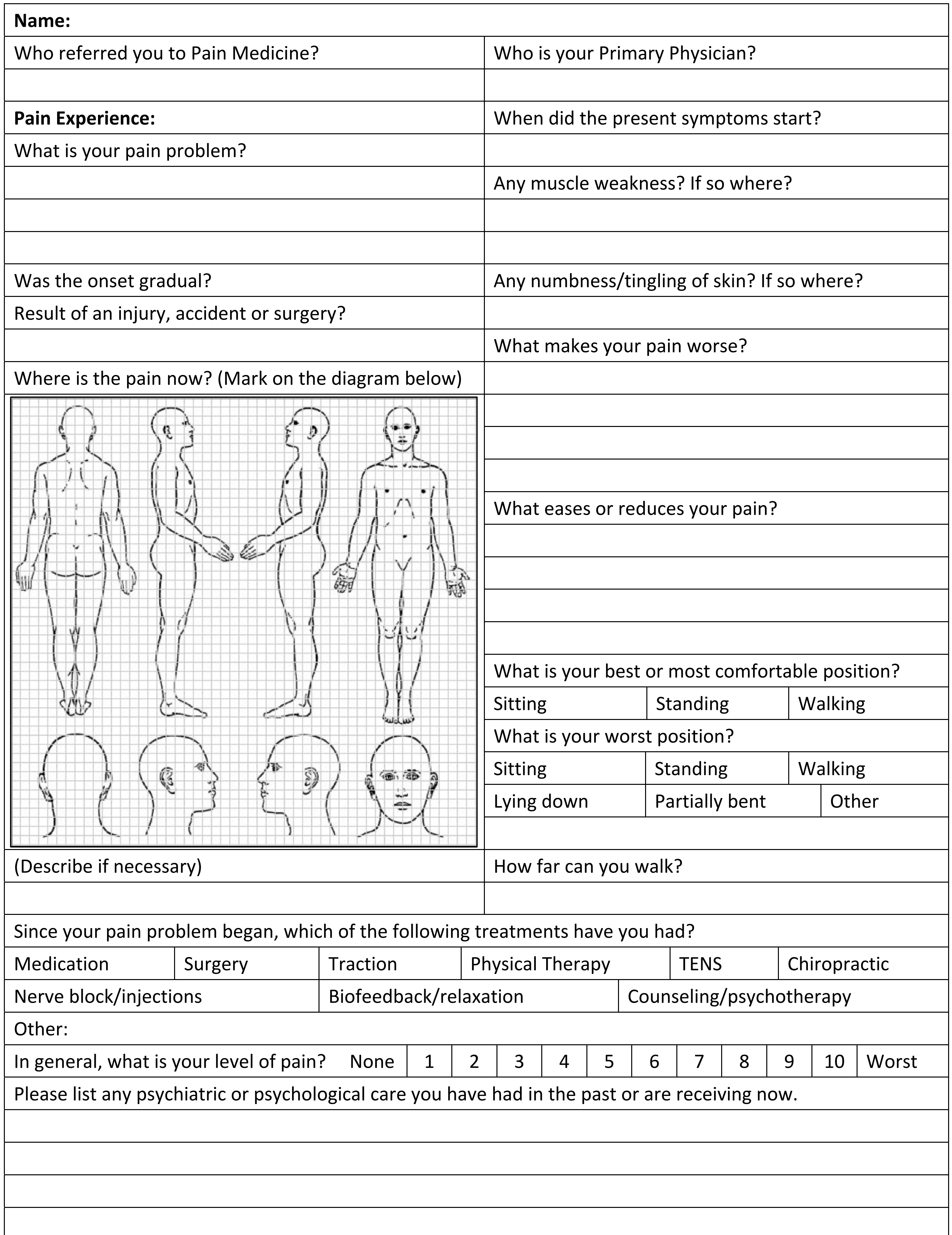
Most recent occupation:		
Are you currently working?	Y	N
If female, any chance you're pregnant?	Y	N

Smoke?	Y	N	Packs a day
Alcohol	Never	Occasional	
Social	Moderate	Heavy	

I have completed a pre-operative review of the patient's history and physical condition, lab and other diagnostic result(s) and approve the patient for the planned procedure.

Physician Signature

Over



Center for Pain Management Questionnaire • Page 2

Name:	
Who referred you to Pain Medicine?	Who is your Primary Physician?
Pain Experience:	When did the present symptoms start?
What is your pain problem?	
	Any muscle weakness? If so where?
Was the onset gradual?	Any numbness/tingling of skin? If so where?
Result of an injury, accident or surgery?	
	What makes your pain worse?
Where is the pain now? (Mark on the diagram below)	
	What eases or reduces your pain?
	What is your best or most comfortable position?
	Sitting / Standing / Walking
	What is your worst position?
	Sitting / Standing / Walking
	Lying down / Partially bent / Other
(Describe if necessary)	How far can you walk?

Since your pain problem began, which of the following treatments have you had?

Medication	Surgery	Traction	Physical Therapy	TENS	Chiropractic
Nerve block/injections		Biofeedback/relaxation		Counseling/psychotherapy	

Other:

In general, what is your level of pain?	None	1	2	3	4	5	6	7	8	9	10	Worst

Please list any psychiatric or psychological care you have had in the past or are receiving now.