

HEALTH AND HISTORY FORM

DATE: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____ DOB: _____

PHARMACY: _____ PHONE #: _____

CHIEF COMPLAINT: Why are you here today? What is bothering you most?

When did these symptoms begin? _____

What caused these symptoms? _____

My problem is located (check and circle all that apply)

- Neck
- Back
- Arm L/R (Shoulder/Elbow/Wrist/Fingers)
- Leg L/R (Hip/knee/ankle/toes)
- Other _____

My pain at REST 0 1 2 3 4 5 6 7 8 9 10; with ACTIVITY is 0 1 2 3 4 5 6 7 8 9 10

My Pain is

- Constant What makes your pain worse? Walking/Bending/Sitting/Lifting/Therapy
- Intermittent What makes your pain better? Rest/Heat/Ice/Therapy/Meds
- Achy What tests have you had? EMG ___ MRI ___ Bone Scan ___
- Dull Xrays ___ CT Scans ___
- Sharp
- Throbbing What treatments have you tried? Therapy/Acupuncture/Injections/
Steroids/Chiropractor
- Stabbing
- Burning
- Tingling What treatment or treatments helped your pain?

Medications:

Allergies:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

No risk to harm myself or others _____ (sign or initial)

Past Medical Problems:

- Heart Disease / CHF/ A-fib/ Valvular Disease/
- High Blood Pressure / High Cholesterol/ Hypothyroidism/ DVT (blood clot)
- Diabetes / Peripheral neuropathy/ Renal failure
- Cancer: Breast/ Lung / Prostate/ Brain/ Liver/ Leukemia/ Ovarian/ Cervical/ Colon
- Lung Disease / COPD / Emphysema / Pulmonary Fibrosis
- Fibromyalgia/ Rheumatoid Arthritis/ Lupus/
- Other: _____

Past Surgeries: CABG____/ Cardiac Stent____/ Lumbar Laminectomy____/Lumbar Fusion____/Cervical Fusion____/ Cervical Laminectomy____/Decompression____/Appendectomy____/ Knee replacement____/ Hip replacement____/ Rotator Cuff Repair____/ Carpal Tunnel Release____/ Kyphoplasty____/ Tonsillectomy: ____/Hysterectomy____/Cataract Removal____/Gall Bladder Removal____/ Organ Transplantation: Heart / Liver / Lung / Kidney / Sm Bowel / Pancreas / Other:_____

Social History:

- Smoke Y/N Packs per day _____
- Alcohol Y/N How much? Daily/Occasionally/Never
- Work Status Unemployed/Employed/Disabled How long?_____
- Married / Single / Divorced / Widowed
- Recreational Drugs Y/N _____

Family History: Please indicate mother, father, etc.

- Heart Disease / Strokes / Diabetes / High Blood Pressure / Other _____

Have you been treated by any other Pain Physicians? Yes / No If yes what is the name of that doctor?_____

What was the reason you discontinued seeing that doctor?_____

When was the last time you were evaluated by that physician?_____