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CONFIDENTIAL

PATIENT MEDICAL HISTORY

Name: _____ Age _____ D.O.B. _____ / _____ / _____ Sex _____ Race _____ (optional)

Height: _____ Weight: _____

Who referred you to us? Doctor, Attorney, Friend, Family Member, etc. _____

Are you currently under the care of a pain management physician? YES ___ NO ___

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

	YES	NO	PLEASE EXPLAIN ALL YES ANSWERS
Stroke	_____	_____	_____
Heart Trouble	_____	_____	_____
High Blood Pressure	_____	_____	_____
Diabetes	_____	_____	_____
Arthritis	_____	_____	_____
Gout	_____	_____	_____
Seizures	_____	_____	_____
Trouble w/Depression or Nerves	_____	_____	_____
Kidney Trouble	_____	_____	_____
Cancer (If yes, where?)	_____	_____	_____
Bleeding Disorder	_____	_____	_____
Alcoholism	_____	_____	_____
Tuberculosis	_____	_____	_____
Lung Disease (Asthma/Emphysema)	_____	_____	_____
Blood Clots	_____	_____	_____
Anemia (low blood)	_____	_____	_____
Ulcers	_____	_____	_____
Liver Disease (Hepatitis)	_____	_____	_____
Thyroid Trouble	_____	_____	_____
Other Major Medical Illness	_____	_____	_____

Reason for Visit (Due to Injury or Accident) Explain _____

LIST ALL SURGICAL PROCEDURES

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

LIST ALL HOSPITALIZATIONS

Reason for Hospital Stay	Date
_____	_____
_____	_____
_____	_____
_____	_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

Name and strength	Dosage (# of tablets)	# of times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATION OR SUBSTANCES? YES ___ NO ___

If yes, please list below:

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

DOES ANYONE IN YOUR FAMILY NOW HAVE OR HAVE THEY EVER HAD ANY OF THE FOLLOWING:

	YES	NO	RELATIONSHIP
Stroke	_____	_____	_____
Heart Trouble	_____	_____	_____
High Blood Pressure	_____	_____	_____
Diabetes	_____	_____	_____
Arthritis	_____	_____	_____
Gout	_____	_____	_____
Seizures	_____	_____	_____
Trouble w/Depression or Nerves	_____	_____	_____
Kidney Trouble	_____	_____	_____
Cancer (If yes, where?)	_____	_____	_____
Bleeding Disorder	_____	_____	_____
Alcoholism	_____	_____	_____
Tuberculosis	_____	_____	_____
Lung Disease (Asthma/Emphysema)	_____	_____	_____
Anemia (low blood)	_____	_____	_____
Liver Disease (Hepatitis)	_____	_____	_____
Sudden Death Before Age 50	_____	_____	_____
Other Major Medical Illness	_____	_____	_____

REVIEW OF SYSTEMS

Have you recently had or do you now have:

Yes	No		Yes	No		Yes	No
_____	_____	Reading Glasses	_____	_____	Tooth Ache	_____	_____
_____	_____	Change of Vision	_____	_____	Gum Trouble	_____	_____
_____	_____	Loss of Hearing	_____	_____	Nausea or Vomiting	_____	_____
_____	_____	Ear Pain	_____	_____	Stomach Pain	_____	_____
_____	_____	Hoarseness	_____	_____	Ulcers	_____	_____
_____	_____	Nosebleeds	_____	_____	Frequent Belching	_____	_____
_____	_____	Difficulty Swallowing	_____	_____	Frequent Loose Bowels	_____	_____
_____	_____	Morning Cough	_____	_____	Frequent Constipation	_____	_____
_____	_____	Shortness of Breath	_____	_____	Blood in Bowel Movements	_____	_____
_____	_____	Chills or Fever	_____	_____	Hemorrhoids	_____	_____
_____	_____	Heart or Chest Pain	_____	_____	Frequent Urination	_____	_____
_____	_____	Abnormal Heart Beat	_____	_____	Burning on Urination	_____	_____
_____	_____	Badly Swollen Ankles	_____	_____	Difficulty Starting Urination	_____	_____
_____	_____	Calf Cramp w/Walking	_____	_____	Difficulty Stopping Urination	_____	_____
_____	_____	Poor Appetite	_____	_____	Get Up Every Night to Urinate	_____	_____

WOMEN ONLY:
 _____ Frequent Headaches
 _____ Blackouts
 _____ Seizures
 _____ Frequent Rash
 _____ Hot or Cold Spells
 _____ Recent Weight Change
 _____ Nervous Exhaustion
 _____ Trouble Sleeping
 _____ Depression
 _____ Nervous Tension
 _____ Irregular Periods
 _____ Vaginal Discharge
 _____ Frequent Spotting

SOCIAL HISTORY

Most Recent Occupation _____

Employer _____

Place of Birth _____

Marital Status: Never Married _____ Married _____
 Divorced _____ Widowed _____

Number of Children _____

Presently Living Alone: YES _____ NO _____

Do You Smoke: NEVER _____ PRESENTLY _____ IN THE PAST _____ # of packs per day _____ # of years _____

Alcohol Use: NEVER _____ OCCASIONAL _____ MODERATE _____ HEAVY _____
 (1-2 drinks a week) (1-2 drinks a day) (More than 2 drinks a day)

Drug Overuse: NEVER _____ PRESENTLY _____ IN THE PAST _____

Blood Transfusion: YES _____ NO _____ If yes, Date _____

Have you been tested for HIV or AIDS? (optional) YES _____ NO _____ (Optional)

Do You Consider Yourself at Risk for HIV or AIDS? (optional) YES _____ NO _____ (Optional)