

Advanced Interventional Pain Management, PA

Patient Name _____ MRN _____

Please help us to get to know you better:

Please list the Physicians that care for you:

Primary Physician _____

Referring Physician _____

Other Physician _____

Are you _____ Single _____ Married _____ Divorced _____ Widowed or widower

Are you Pregnant? No Yes Planning a pregnancy? Yes No

Number of children you have? _____

Are you currently working? No Yes

_____ Fulltime _____ Part-time _____ Unemployed _____ Retired _____ Disabled

What is/was your usual occupation? _____

Do you use tobacco products? No

Yes _____ Chew/Dip _____ Smoke: How long? _____ Packs/day _____

Quit _____ Chew/Dip _____ Smoke: How long? _____ Packs/day _____

How often do you consume alcoholic beverages?

Never Less than one drink per week 1-5/week 6-10/week

11-15/week 16-20/week 21 or more/week

Do you use recreational drugs (street drugs)? No Yes Quit If yes, please list:

What diseases run in your family?

Cancer Diabetes Liver Disease Hypertension COPD Heart Disease

Alcoholism Substance Abuse Thyroid Disorders Kidney Disease Bleeding Disorders

What is the highest level of education you reached? _____

Are you able to operate a vehicle? Yes No

If No, what is your mode of transportation? _____

Do you use any device to help with your mobility?

_____ Cane _____ Wheelchair _____ Walker _____ Motorized Wheelchair

_____ All the time _____ Occasionally _____ As needed _____ Rarely

Have you ever used any of the following devices for your pain and how did it help if at all?

TENS Units	very much	somewhat	not at all	never used
RS4 Stimulator	very much	somewhat	not at all	never used
Heat application	very much	somewhat	not at all	never used
Cold application	very much	somewhat	not at all	never used
Exercise	very much	somewhat	not at all	never used
Mesh glove	very much	somewhat	not at all	never used
Back brace	very much	somewhat	not at all	never used
Splints/Collars	very much	somewhat	not at all	never used
OTC medications	very much	somewhat	not at all	never used

Please list all OTC (over-the-counter) medications you have taken for your pain:

Have you ever been diagnosed with any other medical problems? Circle all that apply.

Sinuses or Allergies	Blurry vision	ringing in the ears	Glaucoma
Dizziness	Skin rashes	Skin cancer	Asthma
Emphysema	COPD	Tuberculosis	Shortness of breath
Chest pain	Heart attack	CABG surgery	Heart arrhythmias
Stomach ulcers	Hiatal hernia	Crohn's disease	Kidney stones
Kidney disease	Hypothyroid	Hyperthyroid	Diabetes
Hepatitis	Stroke	Seizures	Sickle cell disease
Blood clotting problems	HIV/AIDS	Depression	Nervous disorder
High blood pressure	Heart disease	DVT	Intestinal disorder
Other _____			

Please list all surgeries you have had in the past and the approximate date the surgery was performed:

Please tell us what has been done about your pain in the past and the location of treatment center

Visit to the emergency room _____
Pain management program _____
Physical therapy _____
Psychological or psychiatric counseling for pain _____
Any tests- MRI or CT scan Yes No Where? _____ When? _____
Injections or nerve blocks _____
Medications tried and failed _____

Any other Physicians and their addresses you have seen for your pain

Circle the statement(s) that best describe your sleep patterns:

Restful most of the time Difficulty falling asleep Frequent awakenings Disrupted/ poor
Assisted by medication—if yes, please list the medication(s) _____

What do you feel is the cause of your pain? _____

What are your expectations from treatment? _____

Is there anything else you feel is important that we should be made aware of?

Reviewed by _____ Date _____