Florida Regional Pain Management, PA

(PLEASE COMPLETE ENTIRE FORM)

Please complete this form before your first appointment at the ***Florida Regional Pain Management.*** Your careful answers will help us to understand your pain problem and design the best treatment program for you. You may feel concerned about what happens to the information you provide, since most of it is personal. **Our records are strictly confidential**. No outsider is permitted to see your case record without your written permission unless we are required to do so by law (e.g. Workman's Compensation Claims).

Name: …….
LAST FIRST MIDDLE INITIAL

Address …….
STREET ADDRESS

…….
CITY STATE ZIP

Home Phone: (…….) …….. Work Phone: (…….) …….

Referring MD: …… Primary Care MD: ……

Address : …… Address: ……

Phone: (…….) …… Phone: (…….) ……

Fax : (……) …… Fax: (…….) ……

What is the main pain problem for which you are seeking treatment?

……

How long have you had your current pain problem? …… years …… months

How did your current pain start?

❑Injury at work ❑Injury, NOT at work ❑Motor vehicle accident ❑Illness, non-injury

❑Other ……

In general, over the past month, the intensity of my pain has been:

❑Mild ❑Moderate ❑Moderate-severe ❑Severe

Describe your pain (please check all that apply; if there is a dominant quality to your pain, please circle) ❑Burning

❑Sharp ❑Cutting ❑Throbbing ❑Cramping

❑Dull/Aching ❑Pressure-like ❑Shooting ❑Other (describe) ……

❑Numbness ❑Pins and needles

Weakness? Arms ❑right ❑left Dropping objects? ❑yes ❑no

Legs ❑right ❑left Falling? ❑yes ❑no

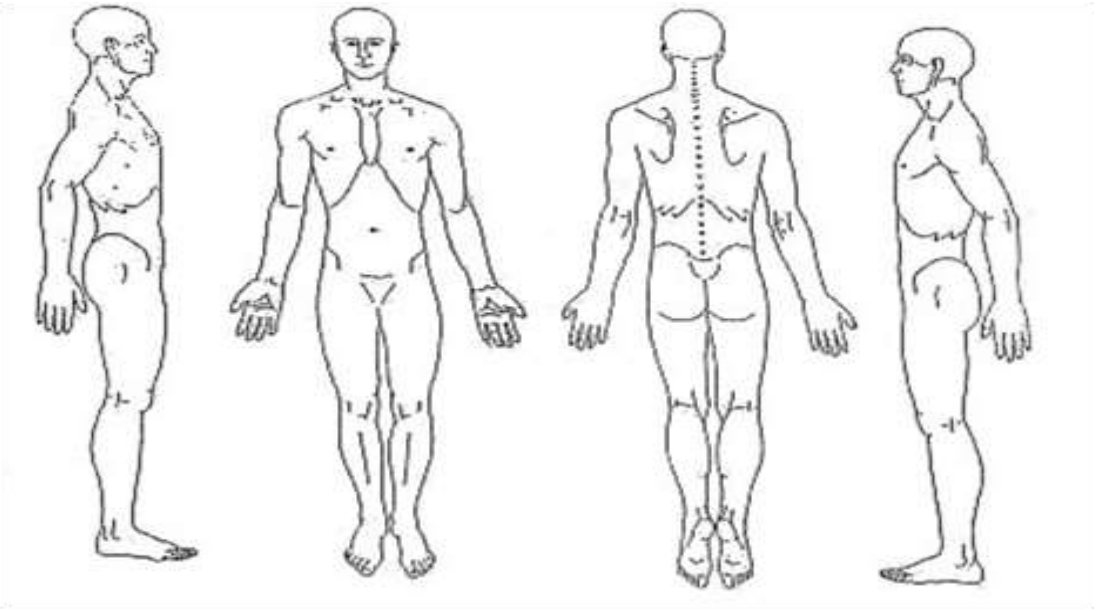
How would you rate your pain? **0** (no pain) **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** (very severe)

What do you miss doing because of your pain?

……

……

PAIN LOCATION: Please mark the location(s) of your pain on the diagrams below with an "X".



Which of these activities of daily living are you **UNABLE** to perform? (Check all that apply)

❑Going to work ❑Performing household chores ❑Doing yard work or shopping

❑Socializing with friends ❑Participating in recreational activities ❑Exercising

Please check your response to all the treatments you have tried:

TREATMENT	NO relief	Moderate relief- duration	Excellent relief- duration
Physical therapy			
TENS			
Nerve blocks/injection			
Surgery			
Other			

ALLERGIES:

Medication allergies ❑Yes ❑No Latex (rubber) allergy ❑Yes ❑No X-ray dye allergy ❑Yes ❑No

……..

PAST MEDICAL HISTORY:

Have you had any of the following health problems? (please check all that apply)

❑Hypertension ❑Coronary artery disease ❑Angina or chest pain ❑Heart attack
❑Diabetes ❑Asthma or wheezing ❑Emphysema ❑Sleep apnea
❑Kidney disease ❑Liver disease (e.g. hepatitis) ❑Stroke ❑Seizure or epilepsy
❑Bleeding problems ❑Treatment with blood thinners ❑Depression ❑Anxiety
❑Thyroid disease ❑Cancer (type) ……...
Other medical problems ……

PAST SURGERIES:

……

……

PAST PAIN MEDICATIONS: Please check all medications you have used in the past for your pain treatment as listed:

ANTIDEPRESSANTS:

❑Elavil (amitriptyline)	❑Imipramine	❑Prozac	❑Lexapro	❑Trazodone
❑Pamelor (nortriptyline)	❑Zoloft	❑Serzone	❑Effexor (venlafaxine)	❑Cymbalta
❑Desipramine	❑Paxil	❑Celexa	❑Welbutrin	❑Other ……

OPIOIDS:

❑hydrocodone (e.g. Vicodin)	❑morphine	❑Oxycontin	❑fentanyl	❑Talwin
❑propoxyphene (e.g. Darvocet)	❑Demerol	❑oxycodone	❑Stadol	❑Levodromoran
❑codeine (Tylenol #3, #4)	❑Dilaudid	❑Percocet	❑methadone	❑Other ……

NSAIDS:

❑Aspirin	❑Daypro	❑Indocin	❑Relafen	❑acetaminophen
❑Motrin	❑trisalisilate	❑Lodine	❑Celebrex	❑Other ……..
❑Naproxen	❑Feldene	❑Orudis	❑Toradol	❑……

MUSCLE RELAXANTS:

❑Soma	❑baclofen	❑Skelaxin	❑Other ……
❑Parafon Forte	❑Zanaflex	❑Valium	
❑Flexeril	❑Robaxin	❑Norflex	

OTHER:

❑Neurontin	❑Depakote	❑Topamax	❑Xanax	❑Imitrex	Other medications:
❑Tegretol	❑Keppra	❑Gabitril	❑Ativan	❑Zomig	……
❑Dilantin	❑Zonegran	❑Klonopin	❑Mexiletine	❑Migranal	……

CURRENT MEDICATIONS FOR PAIN:

NAME	DOSE	HOW OFTEN
1.		
2.		
3.		
4.		
5.		

CURRENT ALL MEDICATIONS (OTHER THAN PAIN MEDICATIONS)

NAME	DOSE	HOW OFTEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

SLEEP DISTURBANCE:

Do you have difficulty falling asleep? ❑Yes ❑No
Do you have difficulty remaining asleep? ❑Yes ❑No
Are you ever awakened by pain? ❑Yes ❑No
Do you use any sleep aids? ❑Yes ❑No Name: ……

FAMILY LIFE: Please specify living arrangements.

❑Living alone ❑Living with spouse/partner ❑Living with spouse/partner and children
❑Living with children ❑Living with friends ❑Living with parents ❑Other ……

PSYCHOLOGICAL TREATMENT:

Have you ever had psychiatric, psychological, or social work evaluation or treatments for any problem, including your current pain?
❑Yes ❑No
What diagnosis were you treated for? ……
When? …… List your current or last therapist(s) ……
……
Have you ever considered suicide? ❑Yes ❑No When? ……
Have you ever attempted suicide? ❑Yes ❑No When? ……

SOCIAL HISTORY:

Do you smoke? ❑Yes ❑No If yes ….. packs For how many years?..… years.
Quit smoking for____ years.
Do you have history of alcoholism? ❑Yes ❑No ❑Current problem.
Have you abused prescription pain medications? ❑Yes ❑No ❑Current problem.
Illegal drugs: ❑Yes ❑No Which one? ……

FAMILY MEDICAL HISTORY: ……

……..…..

REVIEW OF SYSTEMS:

Constitutional
❑Fever
❑Weight loss
❑Weight gain
❑Fatigue
❑Loss of Appetite

Eye
❑Eye pain
❑Blurred vision
❑Glaucoma
❑Light sensitivity

Ears
❑Ear pain
❑Discharge
❑Hearing difficulty/aid
❑Ringing in ears

Nose
❑Pain
❑Discharge
❑Congestion
❑Bleeding
❑Sinus infection

Mouth
❑Jaw pain
❑Toothache
❑Bleeding gums

Throat
❑Sore throat
❑Pain with swallowing

Cardiovascular
❑High blood pressure
❑Chest pain
❑Heart attack
❑Abnormal heart rhythm
❑Pacemaker
❑Blood clots in legs
❑Use of blood thinners

Respiratory
❑Chronic cough
❑Painful breathing
❑COPD
❑Emphysema
❑TB
❑Bloody cough/Sputum

Gastrointestinal
❑Abdominal pain
❑Heartburn
❑Stomach ulcers
❑Constipation
❑Diarrhea
❑Liver/gall bladder problems
❑Jaundice
❑Cirrhosis
❑Hepatitis
❑ Black/bloody stools

Genitourinary
❑Painful urination
❑Blood in urine
❑Bladder infection
❑Flank pain
❑Sexual dysfunction
❑Sexually transmitted disease

Women only
❑Painful menstruation
❑Change in Menstrual Cycle
❑Vaginal discharge
❑Pelvic pain
❑Pain on intercourse

Men only
❑Erectile Dysfunction

Musculoskeletal
❑Arthritis
❑Bursitis
❑Pain/numbness
--shoulder
--arms
--hands
--hip
--legs
--knees
--feet
--tailbone
--sciatica
--swollen joints
--joint replacement

Integumentary
❑Rash
❑Easy bruising
❑Skin cancer
❑Wounds/Bruises

Neurological
❑Headache
❑Seizures
❑Stroke
❑Dizziness
❑Memory loss
❑Loss of coordination
❑Tremors
❑Multiple sclerosis

Psychiatric
❑Alzheimer's disease
❑Depression
❑Anxiety disorder
❑Bipolar disorder
❑Irritability
❑Mood swings
❑Alcoholism
❑Manic episodes
❑Lack of energy

Endocrine
❑Excessive sweating
❑Excessive cold sensation
❑Excessive urine
❑Thyroid disease
❑Diabetes

Hematological/Lymphatic
❑Easy bruising/bleeding
❑Abnormal clotting
❑Blood cancer
❑Swollen glands
❑Sickle Cell Trait/disease
❑AIDS/HIV
❑History of Blood transfusion
❑Family history of hemophilia

Allergic/Immunologic
❑ History of Difficulty breathing or choking
❑ Swollen glands: Groin, neck, under the arms

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PATIENT SIGNATURE

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REVIEWED BY