MOUNTAINSTAR
Lakeview Hospital
Pain Management Center

PAIN MANAGEMENT CENTER PATIENT HISTORY

Name: _____

Please fill in completely (**0**) all circles (**yes and no**) as pertaining to your current symptoms.

Constitutional

weight gain	O Yes	O No
fatigue	O Yes	O No
fever	O Yes	O No
loss of appetite	O Yes	O No

Ophthalmology

drainage from eyes	O Yes	O No
glasses/contacts	O Yes	O No
excess tearing	O Yes	O No
eye pain	O Yes	O No
vision changes	O Yes	O No

ENT

ear pain	O Yes	O No
ear discharge	O Yes	O No
hearing loss	O Yes	O No
ringing in ears	O Yes	O No
ear infection	O Yes	O No
post-nasal drip	O Yes	O No
sore throat	O Yes	O No
bleeding gums	O Yes	O No

Cardiology

chest pain (angina)	O Yes	O No
palpitations	O Yes	O No
heart murmurs	O Yes	O No
shortness of breath	O Yes	O No

Respiratory

cough	O Yes	O No
wheezing	O Yes	O No
shortness of breath	O Yes	O No

Gastroenterology

heartburn	O Yes	O No
peptic ulcers	O Yes	O No
nausea	O Yes	O No
vomiting	O Yes	O No
diarrhea	O Yes	O No
constipation	O Yes	O No
laxative use	O Yes	O No
jaundice	O Yes	O No
loss of bowel control	O Yes	O No

Urology

frequent urination	O Yes	O No
urinary tract infection	O Yes	O No
painful urination	O Yes	O No
urinary retention	O Yes	O No
urinary dribbling	O Yes	O No
loss of urinary control	O Yes	O No

Musculoskeletal

joint pain	O Yes	O No
joint swelling	O Yes	O No
joint stiffness	O Yes	O No
muscle cramps	O Yes	O No
muscle swelling	O Yes	O No

Neurology

tingling/numbness	O Yes	O No
fainting	O Yes	O No
headache	O Yes	O No
weakness	O Yes	O No
dizziness	O Yes	O No

Dermatology

rash	O Yes	O No
skin itching	O Yes	O No
skin infection	O Yes	O No

Endocrinology

hot flashes	O Yes	O No
hair loss	O Yes	O No
always hot	O Yes	O No
always cold	O Yes	O No
excessive thirst	O Yes	O No

Hematology/Lymph

easy bruising	O Yes	O No
easy bleeding	O Yes	O No
swollen lymph nodes	O Yes	O No
anemia	O Yes	O No

Allergy/ Immune system

AIDS	O Yes	O No
allergies	O Yes	O No
frequent infections	O Yes	O No
steroid use	O Yes	O No
hives	O Yes	O No

Psychology

anxiety	O Yes	O No
depression	O Yes	O No
mood swings	O Yes	O No
nightmares	O Yes	O No

Male reproductive

difficulty with erection	O Yes	O No

Female reproductive

pregnant	O Yes	O No

Where is your pain located?

O neck	O shoulder	O upper arm	O forearm	O finger	O low back
O headaches	O thigh	O shin	O toes	O ankle	O groin
O chest	O entire arm	O axilla	O elbow	O hand	O abdomen
O ribs	O buttock	O calf	O foot	O heel	O knee
O mid-back	O facial				

How long have you had your pain?

O 0-6 months O 6-12 months O 1-5 years O 5-10 years O longer than 10 years

In the last 2-3 weeks when does your pain occur?

O intermittent (on/off) O less than 8 hrs/day O 8-16 hrs/day O constant

On a scale of 0 to 10, with 10 being the worst pain, mark where the severity of your pain is.

O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

Associated numbness O Yes O No
Associated Tingling O Yes O No

What was the setting when the problem first occurred?

O alcohol consumption	O animal bite or sting	O infectious disease
O birth-related conditions	O emotional stress	O home
O school or campus	O school-related travel	O toxic substance exposure
O prolonged keyboard activity	O repetitive grasping	O repetitive lifting
O running/jogging	O sports (without obvious trauma)	O squatting
O standing	O straining	O throwing
O walking	O twisting	O weight training
O underwater diving	O stroke (CVA)	O surgery
O reaching	O workplace	O medication
O bending over	O driving	O coughing
O dancing	O having sex	O head movement
O lying down	O none identified	O sitting
O sneezing		

Please describe your pain (quality): O aching O boring or drilling O cold O crushing
O gnawing O hot O nagging O penetrating O pins and needles O pressure
O raw O shock-like O shooting O sore O stinging O throbbing
O tightness O burning O stabbing O mild O heaviness O dull
O moderate O sharp O cramping O severe O other
O quality cannot be determined

Please indicate those activities that INCREASE your pain: (check all that apply)
O work O walking O bending O lying flat O standing O sitting O stress
O alcohol consumption O foods or beverages O locale (i.e. home/work/etc.)
O lying on affected side O medications O menstrual cycle
O physical activities O recreational drug use O sleep-related factors
O toxic substance exposure O travel O underwater diving
O weight gain O other

Please indicate those activities that DECREASE your pain: (check all that apply)
O walking O standing O rest O applying heat O applying cold O injections
O sitting down O physical therapy O relaxation exercises O lying flat O bending
O medications O emergency room treatment O elevating the affected area
O position change O non weight bearing O supporting the extremity O avoiding stress
O massage O moving the area continuously O sleeping O nothing O other

Associated signs/symptoms: O bleeding O bone misalignment O cramping O dizziness
O drainage O drop objects O fatigue O fever O joint problems
O language difficulty O mental status change O muscle tightness O muscle weakness
O nausea O numbness O pain O paralysis O poor sleep O swelling O none

Does your pain affect: O your quality of life O sleep

How many ER visits have you had in the last 3 months for pain?
O 1 O 2 O 3 O 4 O 5 O more than five O none

Do you take any of the following anticoagulants? (check all that apply)
O coumadin O heparin O plavix O fragmin O lovenox O enoxaparin O normiflo
O ardeparin O orgaran O danaparoid

Imaging studies in the last 5 years: O CT scan O EMG (electromyogram) O IVP
O MRI scan O Myelogram O X-rays O Other tests O None

Have you tried any of these therapies: O acupressure O acupuncture
O biofeedback O chiropractors O elevation O exercise O heat O ice
O intradiscal therapy O massage O nerve stimulation O occupational therapy O relaxation
O surgery O none

Have you tried any of these pain clinic treatments: O injection therapy O medications
O physical therapy O other pain centers O psychotherapy O relaxation O surgery
O none

Have you tried the following NSAIDS to help relieve your pain: O iburprofen O aleve
O advil O naproxen O celebrex O toradol O indocin

Are you on Workers Comp? O Yes O No

Mark the appropriate information related to Worker's Compensation:

O Work related travel O trauma and/or injury O unable to work at all since the injury
O able to work with restrictions since the injury O temporary limitations after the injury
O no restrictions now O no work restriction since the injury

Litigation Pending: O Yes O No

If you are involved in any lawsuits, who is the lawsuit against? (Check all that apply)

O Worker's Compensation O Auto Accident O Disability Claim O Other

Have you been to any of the following types of doctors?

O Back Surgeon O Neurologist O Rheumatologist O Other pain doctor

Past Medical History

HTN	O Yes O No	Cancer or Tumor	O Yes O No
Diabetes	O Yes O No	Anemia/Blood disorder	O Yes O No
Arthritis	O Yes O No	Neurological disorders	O Yes O No
Asthma	O Yes O No	Bladder/Kidney disease	O Yes O No
Heart disease	O Yes O No	Liver/gallbladder problems	O Yes O No
Lung disease	O Yes O No	Rheumatic fever	O Yes O No
Stroke	O Yes O No	Thyroid/endocrine problem	O Yes O No
Pancreatitis	O Yes O No	Tension headache	O Yes O No
Bleeding disorder	O Yes O No	Peptic ulcer disease	O Yes O No
Colitis	O Yes O No	Autoimmune disorder	O Yes O No
Anxiety disorder	O Yes O No	Migraine headache	O Yes O No
Seizures	O Yes O No		

Family History

Is your father still alive? O Yes O No
Is your mother still alive? O Yes O No
Do you have children or other dependents at home? O Yes O No

Social History

What is your marital status? O Married O Single O Divorced O Widowed
Are you currently employed? O Yes O No
Are you on disability? O Yes O No
What type of disability do you have?
O Short term O Long term O Social Security O Other

Do you use alcohol to control your pain? O Yes O No

Mark if you use any of the following drugs recreationally:

O Amphetamines O Barbituates O Cocaine O Codeine O Diazepam O Heroin
O Hydrocodone O Marijuana O Oxycodone O Soma

Dependency or addiction to drugs now or in the past? (Check all that apply)

O Amphetamines O Barbituates O Cocaine O Codeine O Diazepam O Heroin
O Hydrocodone O Marijuana O Morphine O Oxycodone O Soma