Pain Management Health History

Name: ____ **DOB:**__________________

Previous or referring doctor:____

Briefly describe your pain symptoms:____

____

____

Pain Level: 0 1 2 3 4 5 6 7 8 9 10

List your current prescribed medications and over the counter drugs

(Or attach current medication list)

Name of Medication	Dose	Frequency Taken

ALLERGIES TO MEDICATIONS:

Name the Medication	Reaction you had

Surgeries:

Year	Type of Surgery	Hospital

Tests:

	Where	Year
MRI		
CT Scan		
EMG/NCV		
X-rays		
EEG		
Blood Work		
Other		

Personal Health History

Do you have or have you ever had any of the following:

Heart Disease
High Blood Pressure
Migraines
Cancer
Multiple Sclerosis
Fibromyalgia
Liver Disease
Lung Disease
Diabetes
Blood Disorder
Hepatitis
Depression
Seizures
Asthma
Stroke
Arthritis
High Cholesterol
Thyroid problems
Anxiety
AIDS/HIV
GI Disorder

Other:____

Social History

Marital Status: Single Divorced Married Separated Widowed

Do you have any children? Yes No If so, how many:________________________

Tobacco (smoking/chewing): Current smoker Former Smoker Never Smoked

Illicit Drugs: Yes No If so, describe:_____________________________________

Caffeine: Yes No If so, how many cups a day:_________________________________

Exercise: Yes No 3-5 times a week Daily Mild None

Personal Safety

Do you have frequent falls? Yes No If so, how often: ________________________

Do you have vision or hearing loss: Yes No If so, how often:________________________

Family History

Please list any medical conditions your immediate family members have been diagnosed with:

Heart Problems: Yes No If so, who:____

High blood pressure: Yes No If so, who:____

Kidney Problems: Yes No If so, who:____

Diabetes: Yes No If so, who:____

Liver Problems: Yes No If so, who:____

High Cholesterol Yes No If so, who:____

Cancer: Yes No If so, who and what kind:_______________________________

Lung disease/Asthma: Yes No If so, who:____

GI/ Stomach Problems: Yes No If so, who:____

Migraine/Headaches: Yes No If so, who:_____________________________________

Bleeding or blood disorder: Yes No If so, who:_____________________________________

Anxiety or Depression: Yes No If so, who:_____________________________________

Tremor: Yes No If so, who: ____

Stroke: Yes No If so, who: ____

Multiple Sclerosis: Yes No If so, who:_____________________________________

Parkinson's disease: Yes No If so, who:_____________________________________

Psychiatric Illness: Yes No If so, who:_____________________________________