Sonoran
PAIN MANAGEMENT

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History Form:

Patient Name:	**Date of Consultation:**
Male or female	
Referring Doctor:	**Primary Care Physician:**
Address:	***Address:***
City:	***City:***
State, Zip	***State, Zip***
Phone	***Phone***

Chief Complaint*:* _____ .

Do you have a particular condition or diagnosis?

_____.

Did a doctor ask you to come to our office for a particular treatment?

_____ _____.

HISTORY OF PRESENT ILLNESS: please indicate on the drawings below where your pain is.

Please circle any of the following symptoms you are experiencing:

Is your problem: Constant, intermittent, frequent, occasional, infrequent

Is the pain: Sharp, Dull, aching, throbbing, burning, tingling, shooting, stabbing, electrical

Is your problem: Mild, Moderate, severe, excruciating

How would you rate your average pain on a scale 0-10:

How long have you been experiencing this problem? _____**.**

Do any of these make the problem worse?
Time of day, sitting, standing, bending, lifting, twisting, crawling , stair climbing, coughing, sneezing, heat, cold, eating, weather changes, light touch, stress, other.

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Do any of the following make the problem better: rest, heat, cold, massage, medication, other _____**.**
.

Are there any factors or symptoms that occur with your problem: such as numbness, muscle weakness, bowel or bladder problems?_____.

What doctors have you seen for this problem? _____.

What tests have you had done for this problem & what were the results, if known?
MRI: _____
CT Scan:_____
X-Rays: _____
EMG/NCS:_____

What treatments have you had for this problem & what were the results?
Surgery: _____
Physical Therapy: _____
Injection or Nerve blocks: _____
Psychological/Behavioral Pain: _____
Osteopathic / Chiropractic: _____
Manipulation: _____
Acupuncture:_____

Current Medications:
Bring all current medications including prescription bottles to office visit.

Name of Pain Medication	Dosage and Number of pill per day
_____	_____
_____	_____
_____	_____
_____	_____

Please list the medicationswhich you currently take FOR OTHER MEDICAL CONDITIONS:

Name of Medication	Name of Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever been diagnosed with or treated for any of the following health problems?
(Please check and circle all items that apply)

_ Angia / Chest pain
_ Angioplasty or Stent for blocked artery
_ Arrhythmia / Atrial Fibrillation / Cardiac Arrest
_ Arthritis (Type?: Osteo. / Rheumatoid)
_ Asthma/ Wheezing
_ Bipolar Disorder
_ Bleeding Disorder (Hemophilia, ITP, ect.)
_ Cancer (Type _____)
_ Chronic Cough
_ Congestive Heart Failure (year?_____)
_ Deep Venous Thrombosis (Blood Clot Leg)
_ Diabetes (___Type I, ___ Type II)
_ Drug or Alcohol Abuse/ Addiction
_ Emphysema, Chronic Bronchitis, or COPD
_ Fibromyalgia
_ Headache (Migraine, Cluster, or Tension?)
_ Heart Attack (year**?**_____**)**
_ Hepatitis (Circle Type: A / B/ C)
_ High Blood Pressure
_ HIV or AIDS
_ Kidney Failure/ Dialysis
_ Liver Disease / Cirrhosis
_ Neuropathy
_ Obesity
_ Pacemaker
_ Paralysis (Describe _____)
_ Pulmonary Embolism (blood clot to the lung)
_ Seizure or Epilepsy
_ Sickle Cell Disease
_ Stomach or Duodenal Ulcer (year_____)
_ Stroke or TIA
_Thyroid Disease (under or overactive?)

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Past surgical history (please list all surgeries you have had & the approximate dates)

_____.
_____.
_____.

Hospitalizations (when & reason)

_____.
_____.
_____.

Accident/ injuries (please list any significant accident or injuries & when they occurred):

_____.

Allergies (list all allergies to MEDICATIONS, food, other items)

_____.

Family History (please list any illness that are present in your family or the cause of death)

_____.
_____.

Social History:

Married Single Divorced Separated Widowed

How many children & grandchildren do you have? Children_____ Grandchildren _____.

If you smoke, how many packs per day & for how many years?_____.

Do you drink, if so how many average per week? _____.

Do you no or have you ever used illegal drugs?_____.

Have you ever been the victim of abuse or violence?_____.

Highest level of education: _____.

Occupational History:

Are you: ____Working _____On Medical Leave _____Disability
____Unemployed _____Retired

Current Occupation (where & how long):

_____.

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Review of Systems
Please **circle** any of the following symptoms that you are experiencing.

Constitutional: diaphoresis , fatigue , fever , insomnia , fever , night sweats , anorexia, chills , malaise , weight gain / loss , recent illness
Eyes: photophobia , vision change , glaucoma
Ears / Nose / Throat / Neck: dental pain , dizziness , dysphagia , epistaxis , neck pain , Facial pain , facial weakness , headaches , hearing loss , hoarseness , neck swelling , tinnitus
Cardiovascular: arrhythmia , chest pain / pressure , claudication , dyspnea , edema , fatigue , palpitations
Respiratory: asthma , pleuritic pain , productive sputum , chest tightness , cough , wheezing
Gastrointestinal: hepatitis , abdominal pain , anorexia , constipation , diarrhea , dysphagia , gastro esophageal reflux , hematemesis , jaundice , nausea , vomiting
Genitourinary / Nephrology: dysuria , flank pain , hematuria , nocturia , pelvic pain , pregnancy , urinary urgency , urinary frequency , urinary incontinence , urinary retention / hesitancy
Musculoskeletal: stiffness , swelling , arthralgia , back pain , bone fracture , bone pain , carpal tunnel syndrome , joint complaint , muscle weakness , myalgias , neck pain , osteoporosis , sciatica , shoulder pain
Dermatologic: rash , cellulites
Neurologic: dizziness , dyskinesia or tremor , gait abnormality , headache , hearing loss , memory loss , mental status change , back pain , facial pain , generalized pain , limb pain , neck pain , paresthesia , seizure , spasms / spasticity , speech difficulty , syncope , tinnitus , vertigo , vision change , weakness
Psychiatric: alcohol abuse , anxiety , depression , drug abuse , hallucination , mania , psychosis , suicidal
Endocrine: hyperthyroidism , hypoglycemia , hypothyroid , obesity , chills
Hematologic / Lymphatic: abnormal bleeding , easy bruising , anemia , prolonged bleeding time , prolonged PT (INR) , prolonged PTT

Functional Status: How long can you:

Sit:_____. Stand:_____.

Walk: _____ Climb Stairs:_____.

Drive: _____

Does pain interfere with daily activities? With any of these:
Recreational activities Housework Yard Work Occupational duties

Patient Goals:

_____

_____

_____

Signature : **Date:**