Centers for Pain Management
New Patient History and Questionnaire

Patient Name:_____

Date of Birth:_____/_____/_____

Primary Care Physician:_____ Phone:(_____)_____-_____

Who referred you to us?_____ Phone:(_____)_____-_____

Reason for today's visit?_____

Is this due to an injury? Yes ___ No ___
If yes, what was the date and place of injury?_____
Area of injury_____ _____ _____
Was this a motor vehicle accident? Yes___ No___
Work related injury? Yes___ No____
Is this a Workman's Compensation claim? Yes ____ No ____

Do you currently have an attorney? Yes__ No ___
If yes, what is their name_____

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Your Medical History (please check all that apply)

Asthma Yes ___ No ___
High Blood Pressure Yes ___ No ___
Stroke Yes ___ No ___
Seizures/Convulsions Yes ___ No ___
Scoliosis Yes ___ No ___
Bleeding Disorder Yes ___ No ___
Stomach ulcers Yes ___ No ___
Thyroid Disorder Yes ___ No ___
Arthritis Yes ___ No ___
Mental Illness Yes ___ No ___
Heart Disease Yes ___ No ___
Rheumatoid Arthritis Yes ___ No ___
Diabetes Yes ___ No ___ Type I ___ Type II ___

Cancer Type_____

Are you pregnant? No ___Yes ___ If yes, how many weeks? _____

Do you have any medical conditions that affect your bones or joints? _____

Please list ALL medications that you are taking including over the counter medications.

Name:_____
Strength:_____
How often:_____

Name:_____
Strength:_____
How often:_____

Name:_____
Strength:_____
How often:_____

Name:_____
Strength:_____
How often:_____

Name:_____
Strength:_____
How often:_____

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How often:_____

Name:_____
Strength:_____
How often:_____

Name:_____
Strength:_____
How often:_____

Name:_____
Strength:_____
How often:_____

Family History

Family Member	Age	Illness	Deceased?	Cause
Mother				
Father				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Son				
Son				
Daughter				
Daughter				

Is there a family history of arthritis? No ___ Yes ___
Type?_____ Who?_____

Is there a family history of Drug use, addiction or abuse? No ___Yes ___
If yes, who?_____

Is there a family history of alcohol addiction or abuse? No ____Yes ___
If yes, who?_____

Allergies:_____
_____
_____

Have you ever been told you are allergic to LATEX? No ___Yes ___
If yes, who told you and under what circumstances?_____
_____

List All Surgeries

_____ Date_____
_____ Date_____
_____ Date_____
_____ Date_____
_____ Date_____
_____ Date_____
_____ Date_____
_____ Date_____

Patient Information

Do you have a history of Drug use, addiction or abuse? No ___ Yes ___
If yes, to what?_____

Do you have a history of alcohol abuse or addiction? No ___ Yes ___
Do you currently drink alcohol? No ___Yes ___
If yes what kind, how much and how often?
_____

Do you use tobacco? No ___ Yes ___ Smokeless tobacco __ Cigar __ Snuff __
If you smoke cigarettes, how many packs per day?
Less than 1 __ 1 __ 2 __ 3 __ more than 3 per day___

Marital status?
Single (never been married) ___ Married ____ Divorced ___ Widowed ___
Separated ___

Current living situation: Alone ___ Spouse ___ Family ___ Friend ___
Assisted Living Facility ____

Are You? Right handed ____ Left handed ___ Both ___

Hobbies/Sports?_____
_____

Are you currently working? No ___Yes ___
Type work_____

Retired? No ___ Yes ___
Type work_____
Have you ever been seen by another pain specialist? No ___ Yes___
Who?_____ Where?_____
Is there a reason you no longer see them?_____
_____

Have you had a recent weight loss? Yes ___No ___
If yes, How much?_____ How long?_____

Have you had a recent weight gain? Yes ___No ___
If yes, How much?_____ How long?_____

Do you have sleep apnea? Yes ___ No ___

Do you use a breathing machine? No ___ Yes ___

Have you had good general health lately? Yes ___ No___
If no, why?_____

Do you have visual problems? Yes ___ No ___
If yes, what?_____
Do you wear glasses? Yes ___ No ___ Contacts? Yes ___ No ___

Have you ever been told you have Hepatitis? Yes ___ No ___
If yes, what type?_____

Do you have dizziness? Yes ___ No ___ Paralysis? Yes ___No ___
Where?_____

Do you have ringing in the ears? Yes ___ No ___ Hearing Loss? Yes ___ No ___
Do you wear a hearing aid(s)? Yes ___No ___ Right ___ Left ___ Both ___

Have you ever had a blood transfusion? Yes ___ No ___
When?_____

Have you ever been exposed to HIV? Yes ___ No ___
When?_____

Please list all Physicians you are currently seeing or have seen in the last year.

Physician Name Address City,State Phone

_____ _____ _____ (___)_____-_____

Physician Name Address City,State Phone

_____ _____ _____ (___)_____-_____

Physician Name Address City,State Phone

_____ _____ _____ (___)_____-_____

Physician Name Address City,State Phone

_____ _____ _____ (___)_____-_____

Physician Name Address City,State Phone

_____ _____ _____ (___)_____-_____