Today's Date: _____

Patient health history

Patient Name: _____ Date of Birth: _____/_____/_____ Age: ____ Gender: ____

Social Security Number: _____ Phone Number: (_____) _____

Alternate Phone Number: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

1. Primary Physician: _____ **2**. Referring physician: _____

Emergency contact: _____Relationship: _____

Phone Number: (_____) _____ Alternate Phone Number: (_____) _____

Current Pharmacy: _____ Phone Number: _____

Chief complaint

Reason for today's visit: _____ Date of onset of symptoms: _____

Where are your pain/symptoms located? _____

Does your pain radiate or travel? Yes / No If yes, where? _____

Do you have numbness or tingling? Yes No If yes, where? _____

Intensity of pain (0 is no pain and 10 is most unbearable)

Pain at present 0 1 2 3 4 5 6 7 8 9 10

Pain at its best 0 1 2 3 4 5 6 7 8 9 10

Pain at its worst 0 1 2 3 4 5 6 7 8 9 10

Can you describe your pain? Sharp Dull Burning

Aching "Shock like" Other _____

Are your pain/symptoms? Constant Intermittent (Come-and-go)

What changes your pain? ↑ Increases ↓ decreases **0** no effect

	Sitting		Sleeping		Walking		Bending forward
	Standing		Weather Changes	◀	Lifting		Bending backward
	Lying Down		Stairs (up or down)		Bowel movement		Working
	Cough/Sneeze		Relaxation		Exercise		Emotional stress
Other:							

Are your pain/symptoms: worse in morning worse at night worse at end of day last all day

Were your symptoms: sudden gradual

Have you experienced episodes or attacks similar to this problem? Yes No

If yes, please describe: _____

Are you off work due to this problem? Yes / No Off since _____/_____/_____

Current problem is a result of: Auto accident Work accident Fall Repetitive Motion

Lifting Unknown Other _____

Have you seen other pain management specialist? Yes / No

Have you ever been discharged from other pain management specialist? Yes / No

Previous treatments

Please check any treatments tried

Treatment	Tried	No Change	Helped	Made worse
Physical Therapy				
Injections:				
Trigger Point				
Epidural Steroid-how many?				
Non Steroidal Anti-inflammatory				
Narcotics				
Muscle Relaxants				
Neck or Back brace				
TENS				
Therapeutic Massage				
Chiropractic Therapy				
Pain management specialist				
Other treatment:				

Current Medical History

Please check all that apply to you

	Seizures		Stroke		Hepatitis
	Migraines		COPD/Emphysema		HIV/AIDS
	Cataracts		Asthma		Kidney Stones
	Sleep Apnea		Hiatal hernia		Prostate problems
	High blood pressure		Stomach reflux		Fibromyalgia
	Heart valve problems		Peptic ulcers		Chronic fatigue
	Heart disease		Bowel/Bladder problems		Arthritis
	High cholesterol		Thyroid disease		Depression
	Blood clotting disorder		Diabetes		Cancer

Other:_____

Are you Right or Left handed? _____ Are you claustrophobic? _____

Do you have any metal in your body? _____ If yes, please explain:_____

Illnesses, Surgeries & Hospitalizations

Illness/Surgery	Year	Physician/Hospital	Complications
1.			
2.			
3.			
4.			
5.			
6.			

Current Medications

Please list all prescription, over the counter and herbal medications.

******If you have a list prepared we will be happy to copy it for you.***

Medication	Dosage	Frequency	Prescribed by	Reason for taking
1.				
2.				
3.				
4.				
5.				
6.				

Are you allergic or sensitive to any medications, latex, contrast dye, tape or foods? Yes / No

If yes, please list: _____ Reaction: _____

_____ Reaction: _____

Family Medical History

If applicable please include: high blood pressure, heart attack, stroke, TIA, aneurysm, bleeding disorder, cancer

Family members	Alive	Age	Cause of Death or Current Health Status
Mother	Yes No		
Father	Yes No		
Sister Brother	Yes No		
Sister Brother	Yes No		
Children	Yes No		
Children	Yes No		

Personal/Social History

Marital History: Single / Married / Divorced / Widowed Number of children: 1 / 2 / 3 / 4 / 5 / 6 / _____

Educational Level: Elementary / High School graduate / Technical school / College – Degree _____

Occupation: _____ Employer: _____ Years employed at present job _____

Do you live alone: Yes / No If no, who do you live with: _____

Do you use tobacco products? Yes / No If yes, Type: _____

Amount: _____ How many years have you used tobacco products? _____

Do you want to quit smoking? Yes / No

Do you drink Alcohol? Yes / No Type and number of drinks per week: _____

Do you have a history of alcohol abuse? Yes / No

Do you have a history of prescription medication use? Yes / No

Do you use or have you ever-used Street/Illicit Drugs? Yes / No Type: _____

Are you at risk for HIV/AIDS due to sexual orientation/behavior, intravenous drug use? Yes / No If yes, please explain: _____

Do you exercise? Yes / No Describe type and frequency: _____Do you have any hobbies? _____

Have you ever received or been referred for treatment for drug/alcohol/ substance abuse? Yes / No

Review of systems: Please check all items that you are having problems with now or in the past.

General

____Fever
____Chills
____Weight gain
____Weight loss

Ears, Eyes, Nose & Throat

____Swallowing difficulties
____Ringing in the ears R L
____Visual changes
___Blurred Vision
___Double Vision
___Loss of peripheral vision

Respiratory

____Shortness of breath
____Wheezing
____Chronic cough

Allergic/immunologic

____Food allergies
____Autoimmune disorders

Cardiovascular

____Chest pain
____Heart palpitations
____ Pain in legs while walking

Gastrointestinal

____ Abdominal Pain
____Diarrhea
____Nausea/vomiting

Genitourinary

____Frequent urination
____Loss of bladder control

Skin

____Rash
____Hair loss

Neurological

____Weakness – Location:
_____
____Memory problems
____Personality changes
____Balance difficulties
____Seizures
____Headaches – location:
_____
____Dizziness
____Fainting spells
____Difficulty with speech
____Facial numbness/weakness
____Problems with arm/leg coordination

Musculoskeletal

____Arthritis – location:
_____
Numbness, tingling, pain:
____Neck
____Shoulders
____Arms
____Elbows
____Hands
____Hips
____Legs
____Knees
____Feet
____Low back

Hematology/Lymphatic

____Bruise easily
____Swollen glands/nodes

Psychiatric

____Depression
____Anxiety
Suicidal thoughts

The above information is accurate to the best of my knowledge: _____ Date: _____
Patient signature

The patient's health history has been reviewed: _____ Date: _____
Physician's Signature

St. John
Pain Services