Medical Pain Management Services, LTD

815-397-8400

Patient Questionnaire

Patient Name: _____ Date_____

General History

Please comment on your general health status. Check any items that are presently a problem, or list any conditions you have that are not seen below.

Height_____ Weight_____

Heart: ☐ Arrhythmia ☐ Heart attack ☐ Coronary artery disease ☐ Angina ☐ Bypass ☐ Pacemaker ☐ Blockage ☐ Valve repair/replacement ☐ Stents ☐ Congestive heart failure ☐ Other_____

Lungs: ☐ Asthma ☐ Pneumonia ☐ Chronic bronchitis ☐ Emphysema ☐ COPD ☐ Smoker # of yrs.___

Liver: ☐ Hepatitis ☐ Cirrhosis ☐ Fatty liver ☐ Enlarged liver ☐ Other _____

Kidney: ☐ Renal failure ☐ Kidney stones ☐ Frequent infections ☐ Other _____

Diabetes: ☐ Non insulin ☐ Insulin dependent ☐ Diet controlled

Hypertension: ☐ Medicated ☐ Diet controlled

Bleeding disorder: ☐ Blood thinners ☐ Hemophilia ☐ Clotting disorder ☐ Anemia ☐ Other _____

Other conditions: ☐ Peripheral vascular disease ☐ Neuropathy ☐ Stroke ☐ TIA ☐ Seizure disorder ☐ Cancer where? _____

Conditions not mentioned, or comments: _____

_____

_____

List **all medications** you take and what you take them for. Include drug name, dose and frequency.

_____

_____

_____

_____

_____

_____

_____

_____

List allergies to medication. Include the drug and your reaction:

_____

_____

_____

_____

_____

Patient History

When did your pain start? _____

_____

What were you doing at the time? _____

_____

Is your pain: ☐ Getting better ☐ Constant ☐ Sporadic ☐ Getting worse ☐ Staying the same

What makes your pain worse? ☐ Walking ☐ Standing ☐ Sitting ☐ Bending forward ☐ Twisting ☐Lying down ☐Other _____

What makes your pain better? ☐ Walking ☐ Sitting ☐ Standing ☐ Lying down ☐ Other _____

_____

Where is your pain now? _____

_____

Check the quality of your pain: ☐ Shooting ☐ Dull Ache ☐ Cramping ☐ Sharp ☐ Burning ☐ Severe Ache ☐ Pressure ☐ Throbbing ☐ Other _____

Comment further if you choose: _____

_____

_____

On a scale of 0-10 (0 being no pain10 being bad enough to go to the ER) your pain level is: (circle)
0 1 2 3 4 5 6 7 8 9 10

Answer the questions below that apply to your condition:

Do you have shooting or radiating pain? ☐Yes ☐ No Where? _____

_____

Do you have numbness or tingling in any extremities? ☐ Yes ☐ No Where? _____

Does the pain inhibit your activity? ☐ Yes ☐ No ☐ Sometimes

Does the pain awaken you? ☐ Yes ☐ No ☐ Sometimes

How often do you take pain medication? (amount of time between doses) _____

_____

What type of work do you do? _____

_____

Which would best describe your work? ☐ Retired ☐ Homemaker ☐ Office ☐ Sales ☐ Construction ☐ Industrial ☐ Other _____

Did your injury happen at work? ☐ Yes ☐ No

Have you been off work due to your present condition? ☐ Yes ☐ No If yes, for how long?_____

Have you applied for Workman's Compensation? ☐ Yes ☐ No

Do you have an attorney involved with your case? ☐ Yes ☐ No Attorney's name address and phone:_____

_____

Have you had back or neck surgery? ☐ Yes ☐ No How many? _____

How long did you get acceptable relief from your **last** back/neck surgery? _____

Did you return to work after surgery? ☐ Yes ☐ No If yes, for how long? _____

Please list **all** surgeries you have had in the past: _____

_____

_____

_____

_____

_____

_____

_____

List any treatments or medications you have tried in the past for your current pain: _____

_____

_____

_____

What pharmacy do you use? _____

Primary Care Physicians name, phone and address_____

_____

_____

Please return this form to our office when you come for your appointment.
If you have any further questions, the physician will answer them in full at the time of your appointment.

Signature:_____Date: _____