

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed

Occupation: \_\_\_ Student \_\_\_ Light work \_\_\_ Sedentary work \_\_\_ Physical work
\_\_\_ Homemaker \_\_\_ Unemployed \_\_\_ Retired \_\_\_ Disabled

Pain Location (body part): \_\_\_\_\_

Pain Level: On a scale of 0 to 10, where 0 is no pain and 10 is the worst pain possible.

What is your current pain level? \_\_\_\_\_

Pain Description - Please describe your pain: (please check all that apply)

- burning chronic constant dull gradual onset
improving intermittent recurrent sharp shooting
stabbing sudden onset throbbing unchanged worsening

Onset / Duration: How long has your pain been persisting? \_\_\_\_\_

What is your dominant hand? \_\_\_ Left \_\_\_ Right Is this a work related injury? \_\_\_ Yes \_\_\_ No

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs.

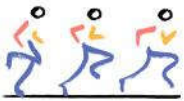
Tobacco Usage: Do you currently smoke or use other forms of tobacco?

\_\_\_ Current every day smoker \_\_\_ Current someday smoker \_\_\_ Former Smoker \_\_\_ I have never smoked

PAST MEDICAL PROBLEMS: Please review the ongoing medical problems, past major illnesses, and hospitalizations below and check the ones that apply to you.

- Abnormal heart rhythm Degenerative arthritis Migraines – chronic
Anemia Depression Miscarriages – chronic
Angina Diabetes Neuropathy
Anxiety Diarrhea – chronic Obesity
Aortic stenosis Enlarged prostate / BPH Osteoarthritis
Asthma Fibromyalgia Osteoporosis
Back pain – chronic Gout Pneumonia – chronic
Bipolar disorder Heart attack Poor circulation / Raynaud’s disease
Bleeding disorder Heart disease Protein in urine – chronic
Bleeding tendency Heart murmur Psoriasis
Blood clot Heart stent Pulmonary embolism – chronic
Cancer – Brain Hepatitis A Reflux
Cancer – Breast Hepatitis B Rheumatoid arthritis
Cancer – Cervix Hepatitis C Seizure – chronic
Cancer – Colon Hiatal hernia Sexual difficulty
Cancer – Kidney High blood pressure Sinus Allergies
Cancer – Lung High cholesterol Sleep apnea
Cancer – Ovary HIV Stomach ulcers
Cancer – Prostate Hyperthyroidism Stroke
Cancer – Skin – Melanoma Hypothyroidism Tuberculosis exposure
Cancer – Thyroid Irritable bowel syndrome Urinary tract infection – chronic
Chest pain Kidney infection – chronic Varicose veins
Cirrhosis Kidney stones – chronic
Congestive heart failure Low platelets
Constipation – chronic Low white cell count
COPD / Emphysema Lupus
Coronary artery disease Menstrual problems

Additional Problems:
I have no past medical problems.



**PAST SURGICAL PROCEDURES:** Please review the procedures listed below and check the ones that apply to you.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Abdominal surgery         | <input type="checkbox"/> Hernia surgery           | <input type="checkbox"/> Sleep apnea surgery                            |
| <input type="checkbox"/> Amputation                | <input type="checkbox"/> Hip replacement          | <input type="checkbox"/> Spine surgery – Cervical                       |
| <input type="checkbox"/> Angioplasty / Heart Stent | <input type="checkbox"/> Hysterectomy             | <input type="checkbox"/> Spine surgery – Lumbar                         |
| <input type="checkbox"/> Aorto-fomoral bypass      | <input type="checkbox"/> Hysterectomy – partial   | <input type="checkbox"/> Spine surgery – Thoracic                       |
| <input type="checkbox"/> Appendectomy              | <input type="checkbox"/> Interventional pain      | <input type="checkbox"/> Thyroidectomy                                  |
| <input type="checkbox"/> Bronchoscopy              | <input type="checkbox"/> Kidney removal           | <input type="checkbox"/> Tonsillectomy                                  |
| <input type="checkbox"/> CABG / Heart bypass       | <input type="checkbox"/> Kidney transplant        | <input type="checkbox"/> Tunneled dialysis catheter                     |
| <input type="checkbox"/> Carotid endarterectomy    | <input type="checkbox"/> Knee arthroscopy         | <input type="checkbox"/> TURP   |
| <input type="checkbox"/> Carpal tunnel release     | <input type="checkbox"/> Knee replacement         | <input type="checkbox"/> Urinary incontinence surgery                   |
| <input type="checkbox"/> Cataract surgery          | <input type="checkbox"/> Kyphoplasty              | <input type="checkbox"/> Vasectomy                                      |
| <input type="checkbox"/> Colon resection           | <input type="checkbox"/> Liver transplant         | <input type="checkbox"/> Vertebroplasty                                 |
| <input type="checkbox"/> Craniotomy                | <input type="checkbox"/> Mastectomy               | <input type="checkbox"/> Anesthesia complications                       |
| <input type="checkbox"/> C-Section                 | <input type="checkbox"/> Mitral valve replacement | <input type="checkbox"/> Surgical complications                         |
| <input type="checkbox"/> Dilation and curettage    | <input type="checkbox"/> Pacemaker                | <input type="checkbox"/> Post-operative delirium                        |
| <input type="checkbox"/> Femoral bypass            | <input type="checkbox"/> Parathyroidectomy        | <b>Additional Surgeries:</b>  |
| <input type="checkbox"/> Fracture repair           | <input type="checkbox"/> Prostatectomy            | _____   |
| <input type="checkbox"/> Gallbladder removal       | <input type="checkbox"/> PTCA                     | _____   |
| <input type="checkbox"/> Gastric surgery           | <input type="checkbox"/> Rotator cuff repair      | _____   |
| <input type="checkbox"/> Heart valve replacement   | <input type="checkbox"/> Shoulder arthroscopy     | _____   |
| <input type="checkbox"/> Hemorrhoidectomy          | <input type="checkbox"/> Shoulder replacement     | <input type="checkbox"/> <b>I have not had any surgical procedures.</b> |

**Have you had ANY surgical procedures in the last 90 days?**  Yes  No

**MEDICATIONS:** Please list any over the counter medications, prescribed medications and supplements you are currently taking. **Please include the name and dosage of the medications.**

**I am not currently taking any medications.**

\_\_\_\_\_

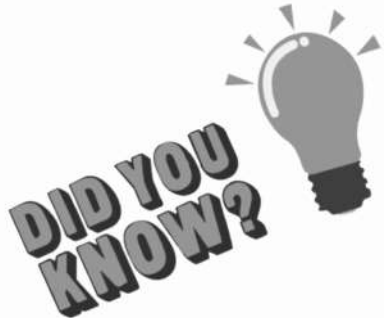
\_\_\_\_\_

**PREFERRED PHARMACY:** Please list the name and phone number of your preferred pharmacy.

**Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

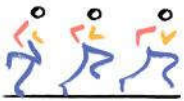
**ALLERGIES:** Please list any allergies you have to medications.  **I have no known allergies to medications.**

\_\_\_\_\_



**You can save time by completing your patient questionnaires online via our patient portal!**

- You can also:**
- with your provider's staff
  - Medical Records
  - Refill
- ✓ Communicate directly
  - ✓ Request a copy of your
  - ✓ Request a Prescription
  - ✓ Submit a Payment



**REVIEW OF SYSTEMS:** Please review the systems below and select your **CURRENT** symptoms.

**GENERAL:**

- chills
- diffuse stiffness
- fatigue / weakness
- fever
- night sweats
- sweats
- weight gain - abnormal
- weight loss - abnormal

**CARDIOVASCULAR:**

- chest pain
- fainting / syncope
- leg swelling
- palpitations
- shortness of breath with exercise
- swelling limbs

**GENITOURINARY:**

- abnormal kidney function
- blood in urine
- frequent urinary infections
- incontinence
- painful urination
- urinary frequency
- urinary hesitancy
- urinary tract infection

**NEUROLOGIC:**

- fainting / syncope
- headaches
- history of seizures
- memory loss
- numbness
- temporary paralysis
- tingling
- tremors
- vertigo / dizziness

**HEMATOLOGY/LYMPHATIC:**

- abnormal bruising
- bleeding
- blood thinning medications
- easy bruising
- enlarged lymph nodes

**EYES:**

- blurred vision
- double vision
- dry eyes
- eye discharge
- eye inflammation
- vision loss

**RESPIRATORY:**

- chest congestion
- cough
- painful breathing
- shortness of breath
- TB exposure
- wheezing

**MUSCULOSKELETAL:**

- arthritis
- back pain
- hip pain
- joint pain
- joint swelling
- muscle soreness

**PSYCHIATRIC:**

- anxiety
- depression
- eating disorder
- feeling of hopelessness
- paranoia
- psychiatric diagnosis
- sleep disturbances
- suicidal thoughts
- tension

**ALLERGIC/IMMUNOLOGIC:**

- HIV exposure
- persistent infections
- sinus congestion

**EAR, NOSE, AND THROAT:**

- difficulty swallowing
- dizziness
- dry mouth
- hearing loss
- impaired hearing
- mouth sores
- nosebleeds
- sore throat

**GASTROINTESTINAL:**

- abnormal pain
- black stool
- blood in stool
- constipation
- diarrhea
- heartburn
- nausea
- vomiting

**DERMATOLOGIC:**

- hives
- itching
- mass / lesion
- open sores
- poor healing
- rash
- skin infection
- tingling / prickly

**ENDOCRINE:**

- blood sugar - abnormal
- excessive hunger
- excessive thirst
- excessive urination
- sensitivity to cold
- sensitivity to heat
- thyroid problems
- weight change

<b><u>OFFICE USE ONLY</u></b>	
Entered:	_____ Yes
By:	_____