PALOUSE
Surgery Center

New Pain Clinic Patient Medical History

Patient Information

Referring Physician_____

Name_____ Date _____

Address_____ Age _____ Male/Female

City _____ State_____ Zip _____

Home Phone (_____) _____ Cell Phone (_____)_____

Primary Insurance _____ Secondary Insurance _____

Workman's Comp Information _____ Claim # _____

Blood Thinners

Are you taking any Blood-Thinners (including Aspirin & Anti-Inflammatory drugs)? ☐Yes ☐No

If you are taking any Blood Thinners have you stopped taking them prior to the injection? ☐Yes ☐No

Health History

Current Weight _____ Current Height _____

Put an "X" in front of each condition that applies to you. ☐ **NO PERTINENT PAST MEDICAL HISTORY**

____ High Blood Pressure
____ Heart Attack
____ Stroke
____ Arrhythmia
____ Congestive Heart Failure
____ Asthma
____ Emphysema
____ Cancer
____ Kidney Disease
____ Migraines
____ Seizures
____ Diabetes
____ Liver Disease
____ Ulcers
____ Mental Illness
____ Glaucoma
____ Bleeding Disorder
____ Hepatitis

Social History

Are you currently employed? ☐Yes ☐No What is your occupation? _____

Place of employment _____

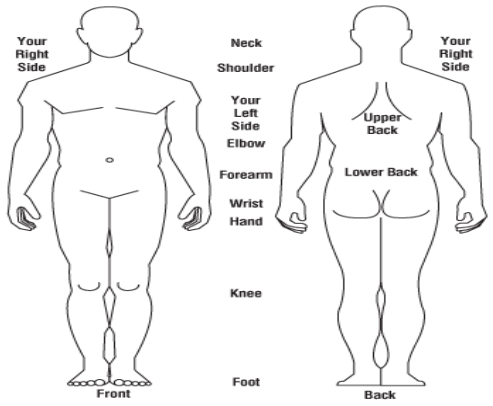
If not currently working, when did you last work? _____

Are you on disability? ☐Yes ☐No, If Yes, since when?_____ Why? _____

Pain Description

What is the **WORST** area of your pain? _____

****<u>Draw your pain on the diagram below</u>****



Does your pain radiate? ☐No ☐Yes, Where: _____

When did pain begin? _____

What caused your **CURRENT** pain? _____

Is your pain (circle one): CONSTANT / INTERMITTENT

<u>Which of the following best describes your pain?</u>

☐ Shooting/Stabbing ☐Stinging/burning ☐Other:

<u>Which of the following **INCREASE** your pain?</u>

☐ Coughing/Sneezing ☐ Sitting ☐Driving

☐Walking ☐Standing ☐Other:_____

☐Lifting everyday objects (ex. Groceries, books)

List things that **IMPROVE** your pain (if any): _____

Circle the number that best describes your pain:

0 1 2 3 4 5 6 7 8 9 10

←----------→

NO PAIN DISTRESSING PAIN UNBEARABLE PAIN

Have you tried any of the following for your **CURRENT** pain?

Physical Therapy	☐ Yes ☐ No	Did it help?	☐ Yes ☐ No
Massage Therapy	☐ Yes ☐ No	Did it help?	☐ Yes ☐ No
Chiropractic Therapy	☐ Yes ☐ No	Did it help?	☐ Yes ☐No

Other Treatments: _____

Have you had any of the following studies done for your pain?

☐ MRI/CT Scan When?(Approx.)_____ Where _____

☐ X-Ray When?(Approx.)_____ Where _____