



# PREMIER PAIN TREATMENT INSTITUTE

Improving quality of life, one person at a time

## New Patient Medical Questionnaire

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

Date of Birth: \_\_\_\_\_ Referring Provider: \_\_\_\_\_

**Please fill out this questionnaire as completely as possible. All health information will remain confidential in accordance with the HIPAA privacy laws.**

Primary location of your pain: \_\_\_\_\_

Date that your pain began (month and year if possible): \_\_\_\_\_

Cause of your pain, if known: \_\_\_\_\_

Additional areas of pain: \_\_\_\_\_

Frequency of your pain:  Occasional  Frequent  Constant

Describe your pain:  Sharp  Stabbing  Aching  Burning  Dull  
 Numb  Throbbing  Tingling  Cramping  Gnawing

Average pain score:  0  1  2  3  4  5  6  7  8  9  10

Pain improves with:  Rest  Lying down  Sitting  Standing  Walking  
 Changing positions  Bending forward  Nothing

Pain worse with:  Sitting  Standing  Walking  Running  Kneeling  
 Bending backward  Bending forward  Lifting

Associated symptoms:  Numbness  Weakness  Tingling  
 Loss of bladder function  Loss of bowel function

### Previous Treatment

Previous pain management doctor(s): \_\_\_\_\_

Therapies:  Physical therapy  Occupational therapy  Chiropractor

Previous imaging/tests:  X-rays  CT scan  MRI scan  Bone scan  
 Genetic testing  EMG

Previous injections:  Epidural  Nerve block  Radiofrequency  Joint  
 Trigger point  Spinal cord stimulator  Pain pump

Previous surgeries:  Neck  Back  Knee  Hip  Shoulder

Other treatments:  TENS unit  Brace  Other: \_\_\_\_\_

Mental health:  Psychiatrist (Name and Phone: \_\_\_\_\_)  
 Psychologist (Name and Phone: \_\_\_\_\_)



# PREMIER PAIN TREATMENT INSTITUTE

Improving quality of life, one person at a time

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

DOB: \_\_\_\_\_

## Medication List

Allergies: \_\_\_\_\_

List all medications you are currently taking (attach list if necessary):

Medication	Dose	Frequency

Please circle the names of ALL medications that you have taken previously:

Opioids: Oxycodone, Percocet, Oxycontin, Norco, Vicodin, Lortab, Hysingla, Zohydro, Morphine IR/ER, MS Contin, Hydromorphone, Dilaudid, Exalgo, Butrans, Methadone, Fentanyl TD, Opana IR/ER, Tramadol, Codeine, Nucynta IR/ER

Neuropathic: Gabapentin, Neurontin, Lyrica, Cymbalta, Topamax, Amitriptyline, Elavil, Savella, Clonidine, Gralise, Lidoderm Patch, Lidocaine ointment

Relaxants: Cyclobenzaprine, Flexeril, Baclofen, Tizanidine, Zanaflex, Methocarbamol, Robaxin, Skelaxin, Soma, Norflex, Valium

NSAIDs: Ibuprofen, Naproxen, Aspirin, Meloxicam, Diclofenac, Celebrex, Daypro, Relafen, Toradol, Indomethacin, Duexis, Vimovo, Voltaren gel

## Past Medical History (circle all that apply)

Heart: High blood pressure, High cholesterol, Coronary artery disease, Heart attack, Irregular heart rhythm, Pacemaker, Congestive heart failure, Heart valve disease

Lungs: COPD, Bronchitis, Emphysema, Asthma, Sleep apnea, Sarcoidosis, Tuberculosis

GI: GERD, Ulcers, Hiatal hernia, Constipation, Irritable bowel syndrome, Crohn's disease, Ulcerative colitis, Liver cirrhosis, Chronic pancreatitis

Endocrine: Diabetes (insulin dependent?), Hypo/hyperthyroid, Adrenal insufficiency

Infectious: Hepatitis A/B/C, HIV/AIDS, Recent infection (Type: \_\_\_\_\_)

Renal: Renal insufficiency, Renal failure, Dialysis, Kidney stone

M/S: Osteoarthritis, Rheumatoid arthritis, Fibromyalgia, Ehlers-Danlos Syndrome

Neuro: Peripheral neuropathy, Multiple sclerosis, Seizure disorder, Stroke, Migraines

Heme/Onc: Cancer (Type: \_\_\_\_\_), Bleeding Disorder (Type: \_\_\_\_\_)

Psychiatric: Depression, Anxiety, Bipolar, Schizophrenia, History of suicide attempt



# PREMIER PAIN TREATMENT INSTITUTE

Improving quality of life, one person at a time

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

DOB: \_\_\_\_\_

## Past Surgical History (list all surgeries and dates)

---

---

---

## Social History

Smoking Status:     Nonsmoker     Former     Current: \_\_\_\_\_ packs/day for \_\_\_\_\_ years

Alcohol Use:         None             Social     Regular  
Alcoholic beverages per week: \_\_\_\_\_

Street Drug Use:     No     Yes  
If Yes:  Marijuana     Cocaine     Heroin     Other: \_\_\_\_\_

Unprescribed Pain Medication:     No     Yes    If Yes, which drug? \_\_\_\_\_

Marital Status:     Single     Married     Divorced     Widowed

Family Support:     Adequate     Inadequate

Employment Status:  Full time     Part time     Unemployed     Retired  
 Short term disability     Long term disability

## Family History (if unknown, check here )

For each family member below, please indicate age, alive/deceased, and any health problems.

List of common health problems (for reference): High blood pressure, heart disease, heart attack, abnormal heart rhythm, asthma, COPD, liver disease, diabetes, kidney failure, osteoarthritis, fibromyalgia, stroke, cancer, bleeding disorder, depression, anxiety, suicide

Father (age \_\_\_\_\_;  Alive  Deceased) Conditions: \_\_\_\_\_

Mother (age \_\_\_\_\_;  Alive  Deceased) Conditions: \_\_\_\_\_

Paternal Grandfather (age \_\_\_\_\_;  Alive  Deceased) Conditions: \_\_\_\_\_

Paternal Grandmother (age \_\_\_\_\_;  Alive  Deceased) Conditions: \_\_\_\_\_

Maternal Grandfather (age \_\_\_\_\_;  Alive  Deceased) Conditions: \_\_\_\_\_

Maternal Grandmother (age \_\_\_\_\_;  Alive  Deceased) Conditions: \_\_\_\_\_

## Fall Risk Screening (if you are older than 65, check the most appropriate)

- No falls in the past year
- One fall in the past year **without** injury
- $\geq$  Two falls in the past year **without** injury
- One fall in the past year **with** injury
- $\geq$  Two falls in the past year **with** injury



# PREMIER PAIN TREATMENT INSTITUTE

Improving quality of life, one person at a time

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

DOB: \_\_\_\_\_

## Review of Systems

Please check all symptoms or conditions that are present at this time:

### General:

- Fatigue
- Fever
- Chills
- Night sweats
- Weight loss
- Weight gain

### HEENT:

- Headache
- Vision change
- Eye pain
- Runny nose
- Sinus infection
- Nose bleed
- Sore throat
- Dental problems
- Hearing loss

### Cardiovascular:

- Chest pain
- Palpitations
- Loss of consciousness
- Leg swelling
- Heart murmur
- Abnormal EKG
- Blood clot

### Respiratory:

- Shortness of breath
- Wheezing
- Cough
- Sleep apnea
- Home oxygen use

### Skin:

- Rash
- Open sore
- New lesion

### Gastrointestinal:

- Nausea
- Vomiting
- Diarrhea
- Abdominal pain
- Loss of appetite
- Heartburn
- Constipation
- Loss of bowel control

### Genitourinary:

- Pregnant
- Painful urination
- Blood in urine
- Recent urinary infection
- Loss of bladder control
- Testicular pain
- Vaginal bleeding
- Pelvic pain

### Endocrine:

- Excess thirst
- Heat or cold intolerance
- High blood sugar
- Frequent urination

### Musculoskeletal:

- Neck pain
- Back pain
- Joint pain
- Muscle pain/spasms

### Neurological:

- Numbness
- Tingling
- Weakness
- Dizziness
- Blurred vision
- Tremors
- Seizure
- Abnormal gait
- Speech change

### Hematologic:

- Easy bruising
- Easy bleeding
- Blood thinner
- Anemia
- Transfusion

### Psychiatric:

- Anxiety
- Panic attacks
- Depression
- Insomnia
- Hallucinations
- Hopelessness
- Suicidal
- Homicidal



# PREMIER PAIN TREATMENT INSTITUTE

Improving quality of life, one person at a time

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

DOB: \_\_\_\_\_

## Pain Diagram

Please mark all areas of pain with XXXXX. Please circle all areas of numbness/tingling.

