Interventional Pain Physicians Of South Florida

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Questionnaire filled out by: _____

PAIN PATIENT QUESTIONNAIRE DATE: _____

1. Patient's Full Name: _____

2. Patient's Age: _____ DOB: _____ Sex: ◯ Male ◯ Female

3. Race: ◯ Caucasian ◯ Black ◯ Hispanic ◯ Other (specify_____)

4. Primary Physician: _____ Phone Number: _____

5. Referring Physician: _____ Phone Number: _____

6. What is the main complaint for which you are seeking treatment at the Pain Center?

_____

_____

7. How long have you had the pain problem you are currently experiencing?

_____

8. How did your current pain start? _____

*Are you doing any stretching and exercises for your specific condition? Yes ◯ No ◯

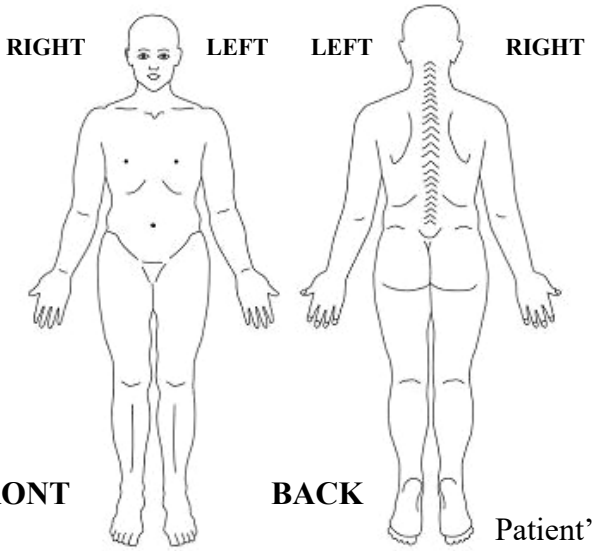
When did you start?_____

9. Have any other Health Care Professionals and/or Specialist been involved in the evaluation and treatment of your current pain? (Please specify)

_____

_____

PLEASE MARK WHERE YOUR PAIN IS LOCATED



Choose a number from the chart below that best describes:

Your pain now: _____ (0-10)
Your pain at its worst: _____ (0-10)
Your goal for pain relief: _____(0-10)

10. Please list all of the medications you **have ever tried** for your **current pain problem**.

_____

_____

12. Please check all of the treatments **you have tried for your pain** from the list below, and complete the appropriate columns at the right.

TREATMENT	DATES	RESULTS
___ Hospital Bed rest	_____	_____
___ Traction	_____	_____
___ Surgery	_____	_____
___ Acupuncture	_____	_____
___ TENS (Electrical Stimulator)	_____	_____
___ Physical Therapy	_____	_____
___ Chiropractor	_____	_____
___ Epidural, Nerve Block, Neuroforaminal injections	_____	_____
___ Exercise – Circle: Structured program, Yoga, Tai Chi, Self gym, Pilates, walking	_____	
___ Have you had steroid injections of any body part?	_____	_____
___ Other – Specify or circle: Therapeutic massage, aquatic therapy, etc.		_____

12. How often do you have pain?_____

13. Check any symptoms and adjectives associated with your pain:

___ Numbness	___ Weakness	___ Urinary Incontinence
___ Redness	___ Swelling	___ Tenderness of affected area
___ Cool, pale skin	___ Burning	___ Pain with only a light touch
___ Mild	___ Shooting	___ Prevents family duties
___ Moderate	___ Stabbing	___ Prevents social duties
___ Strong	___ Tingling	___ Affects appetite
___ Dull	___ Cramping	___ Throbbing
___ Aching	___ Squeezing	___ Sexual Dysfunction

14. Does your pain affect your sleep? No◯ Yes◯ Falling asleep? No◯ Yes◯
Are there any factors that make your pain:
Better? (Please list)_____
Worse? (Please list) _____

15. During the past month, is your pain worse in the:
___ Morning ___ Afternoon ___ Evening ___ Night ___ No typical pattern

16. Have you ever had psychiatric or psychological evaluation or treatment for the problems including your current pain? No◯ Yes◯

17. Have you had any CT scans or MRI for your current pain problem? No◯ Yes◯
If Yes, at what facility? _____

18. Do you have any drug allergies? (Please list)_____

_____

19. Are you allergic to seafood? ◯No ◯Yes 20. Allergic to Latex? ◯No ◯Yes

20. Do you have a pacemaker? ◯No ◯Yes 22. Allergic to Sunscreen? ◯No ◯Yes

21. Have you ever had surgery? (Please list in detail)

Surgery Date Doctor or Hospital

_____

_____

_____

22. Do you have any family history of major illness? ◯No ◯Yes If yes, please list:

MOTHER'S SIDE FATHER'S SIDE

_____ _____

_____ _____

23. Are your parents deceased? Mother: ◯No ◯Yes Father: ◯No ◯Yes

24. Do you have any siblings? ◯No ◯Yes How Many? _____

Do they have a medical history? ◯No ◯Yes If yes, please specify:

Medical History _____

25. Aside from your pain problem, how is your general health? (Please check one)

___ Excellent ___ Minor health problem only ___ Major Health problems

26. Have you had any of the following health problems? (Please check all that apply)

General

___ Hearing Loss ___ Eye disorders ___ Skin Disorders/Type: _____

___ Cancer Location: _____ Treatment: _____

Cardiovascular Health

___ Chest Pain ___ Heart Attack ___ Stroke ___ Dizziness

___ High Blood Pressure ___ Phlebitis ___ High Cholesterol

___ Fainting ___ Irregular Heartbeat (Type: _____)

Pulmonary

___ Chronic Cough ___ Asthma ___ Tuberculosis ___ COPD ___ Pneumonia

___ Emphysema ___ Oxygen use ___ CPAP use ___ Snoring ___ Bronchitis

___ Shortness of Breath ___ Wheezing ___ Sleep Apnea

Gastrointestinal

___ Ulcers ___ Pancreatitis ___ Jaundice ___ Constipation ___ Colostomy

___ Diverticulitis ___ GERD ___ Hepatitis (Type: _____) ___ Gallbladder Disease

Endocrine

___ Diabetes ___ Thyroid Disorder

Hematology
___ Bleeding disorder ___ Anemia

Neurological
___ Numbness in left arm ___ Syncope ___ Numbness ___ Headache ___ Loss of bladder control
___ Memory loss ___ Seizures ___ Stroke or mini stroke (TIA) ___ Tingling/numbness ___ Paralysis
___ Low back pain ___ Numbness in both arms ___ Parkinson's Disease ___ Muscle weakness
___ Memory deficit ___ Paralysis ___ CVA/TIA ___ Seizures ___ Meningitis
___ Headaches ___ Depression ___ Anxiety ___ Numbness/Tingling-arms, legs, face, hands, feet

Genitourinary
___ Sexually Transmitted Disease (Specify: _____) ___ Impotence ___ Urination difficulty
___ Prostate disease ___ Kidney disease ___ HIV/AIDS ___ Incontinence

Bone/Joint
___ Arthritis or joint disease ___ Bone or Joint surgery in past year ___ Carpal Tunnel
___ Swollen joints ___ Sciatica ___ Painful joints ___ Muscle Aches ___ Joint stiffness
___ Weakness ___ Osteoporosis ___ Spasms ___ Neck pain ___ Back pain ___ Joint injections in the last year

Other Not Listed:
_____

27. Marital Status: _____ Children (how many): _____
28. Height: _____ Weight: _____
29. Do you smoke? ○No ○Yes -If yes, how many packs per day? _____ How many Years? _____
30. Do you drink alcoholic beverages? ○No ○Yes If yes, how often? _____
31. Do you use any recreational drugs? ○No ○Yes If yes, what? _____
32. Are you actively involved in any recovery, treatment and/or monitoring programs if yes what?
_____

33. Currently working? ○No ○Yes If no why? _____
Is your current work status considered FULL DUTY? ○No ○Yes
If no, please explain? _____
What is your occupation? _____
Please Describe? _____

34. Would you return to work if you had no pain problem? ○No ○Yes ○Full Time ○Part Time

35. What number best describes your pain on average in the past week? 0-10 _____
36. What number best describes how, during the past week, pain has interfered with your enjoyment of life? 0-10 _____
37. What number best describes how, during the past week, pain has interfered with your general activity? 0-10 _____

Patient's Signature_____

Patients Name: _____

Eforce _____