

INTERVENTIONAL SPINE SPECIALISTS OF FLORIDA

Patient Information

Today's date: _____

Your name: _____ Date of Birth: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

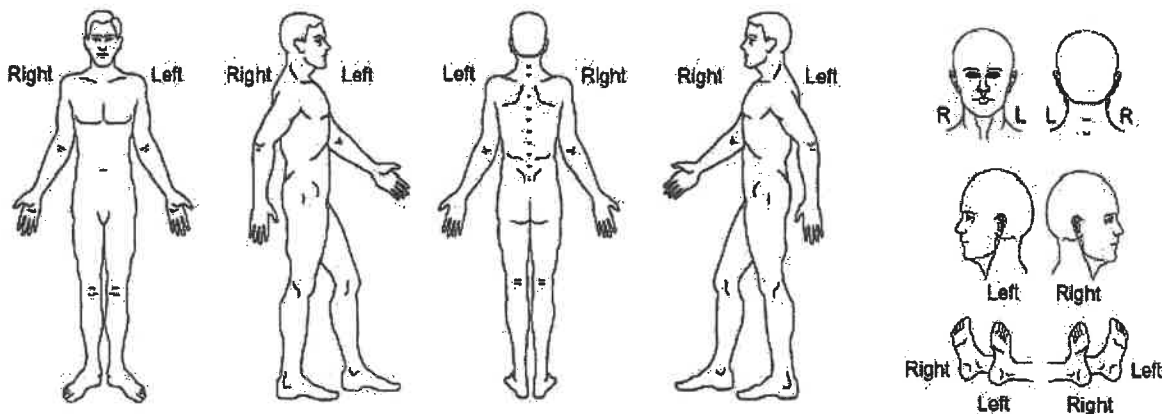
Pain History

Chief Complaint* (Reason for your visit today)? _____

Does this pain radiate? If so where? _____

Please list any additional areas of pain: _____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Onset of Symptoms

Approximately, when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? Gradually Suddenly

Since your pain began, how has it changed? Improved Worsened Stayed the same

Pain Description

Describe the character of your pain (eg: dull, stabbing, throbbing, etc):

What time of day is your pain at its worst? _____

How often does the pain occur?

- Constant Changes in severity but always present Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now _____ The Best It Gets _____ The Worst It Gets _____

What other factors worsen or affect your pain?

What other factors relieve your pain?

Are there any associated symptoms? (eg: numbness/tingling/weakness/incontinence, etc)

What are the goals you wish to achieve with Pain Management? _____

Diagnostic Tests and Imaging

Mark all of the following tests that you have had related to your current pain complaints:

- MRI of the: _____ Date: _____
- X-Ray of the: _____ Date: _____
- CT Scan of the: _____ Date: _____
- EMG/NCV study of the: _____ Date: _____
- Other Diagnostic Testing: _____ Date: _____
- I have not had ANY diagnostic tests for my current pain complaint

Please mark all of the following treatments you have had for pain relief:

	No Change	Worsened Pain	Helped Pain
Spine Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brace Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot/Cold Packs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TENS Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Interventional Pain Treatment History

- Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar
- Joint Injection – Joint(s) _____
- Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar
- Nerve Blocks – Area/Nerve(s) - _____
- Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar
- Spinal Cord Stimulator – Trial Only/Permanent Implant _____
- Trigger Point Injections – Where? _____
- Vertebroplasty/Kyphoplasty – Level(s) _____
- Other - _____
- Which of these procedures listed above have helped with your pain? _____
- _____

Please list the names of other Pain Physicians you have seen in the past?

Mark the following physicians or specialists you have consulted for your current pain problem(s):

- | | | |
|--|---|--|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Psychiatrist/Psychologist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Orthopedic Surgeon | <input type="checkbox"/> Rheumatologist |
| <input type="checkbox"/> Internist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Neurologist |
| <input type="checkbox"/> Other _____ | | |

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

Cancer/Oncology

- Cancer - Type _____
- Cancer - Type _____
- Cancer - Type _____

Cardiovascular/Hematologic

- Anemia
- Heart Attack
- Coronary Artery Disease
- High Blood Pressure
- Peripheral Vascular Disease
- Stroke/TIA
- Heart Valve Disorders
- Presence of stent/pacemaker/defibrillator

Gastrointestinal

- GERD (Acid Reflux)
- Gastrointestinal Bleeding
- Stomach Ulcers
- IBS/Crohns Disease

Urological

- Chronic Kidney Disease
- Kidney Stones
- Urinary Incontinence
- Dialysis

Neurological

- Multiple Sclerosis
- Peripheral Neuropathy
- Seizures
- Balance Disorder
- Head Injury
- Headaches
- Migraines

ENT

- Glaucoma
- Vertigo
- Hearing Problems
- Nosebleeds

Respiratory

- Asthma
- Bronchitis/Pneumonia
- Emphysema/COPD

Musculoskeletal/Rheumatologic

- Bursitis
- Carpal Tunnel Syndrome
- Fibromyalgia
- Osteoarthritis
- Osteoporosis
- Rheumatoid Arthritis
- Chronic Joint Pains

Psychological

- Depression
- Anxiety
- Schizophrenia
- Bipolar Disorder
- ADD/ADHD
- PTSD

Endocrinology

- Diabetes - Type _____
- Hyperthyroidism
- Hypothyroidism

Other Diagnosed Conditions

- _____
- _____
- _____
- _____

Past Surgical History

Please list any surgical procedures you have had done in the past including date:

- 1) _____ Date? _____
- 2) _____ Date? _____
- 3) _____ Date? _____
- 4) _____ Date? _____
- 5) _____ Date? _____

I have **NEVER** had any surgical procedures performed.

Family History

Mark all appropriate diagnoses as they pertain to your parents and siblings:

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke | |

Other Medical Problems: _____

I have no significant family medical history

Social History

Occupation: _____ When was the last time you worked? _____

Who is in your current household? _____

Are there any stairs in your current home? _____ If so how many? _____

Temporary Disability Permanent Disability Retired Unemployed

Are you currently under worker's compensation? No Yes

Is there an ongoing lawsuit related to your visit today? No Yes

Alcohol Use:

Social Use Daily use of alcohol Never History of alcoholism Current alcoholism

Tobacco Use:

Current user Former user Never used

Packs per day? _____ How many years? _____ Quit Date: _____

Illegal Drug Use:

Denies any illegal drug use Currently uses illegal drugs Formerly used illegal drugs (not currently)

Have you ever abused narcotic or prescription medications? Yes No

Current Medications

Are you currently taking any blood thinners or anti-coagulants? YES No

If YES, which ones? Aspirin Plavix Coumadin Lovenox Other _____

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

	<u>Medication Name</u>	<u>Dose</u>	<u>Frequency</u>
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____
7)	_____	_____	_____
8)	_____	_____	_____
9)	_____	_____	_____
10)	_____	_____	_____

Please list all past pain medications that you have been on at any point for your current pain complaints?

	<u>Medication Name</u>	<u>Dose</u>	<u>Frequency</u>
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

Only if any of your medications cause constipation, please answer these questions. If not, skip this section.

On average, how often do you have a bowel movement?

(Please check one)

- | | |
|--|--|
| <input type="checkbox"/> More than 3 times per day | <input type="checkbox"/> 2 to 3 times per day |
| <input type="checkbox"/> Once per day | <input type="checkbox"/> 2 to 3 times per week |
| <input type="checkbox"/> Less than once per week | |

Think back to when you started pain medicine. Did your bowel habits change? If so how?

Allergies

Do you have any drug/medication allergies? Yes No

If so, please list all medications you are allergic to

<u>Medication Name</u>	<u>Allergic Reaction</u>
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

Topical Allergies: Latex Iodine Tape IV Contrast

Review of Systems

Mark the following symptoms that you currently suffer from:

Constitutional: Fevers Chills Sweats Weakness Fatigue Decreased Activity Malaise
 Unexplained weight gain Unexplained weight loss Low sex drive Difficulty sleeping

Eyes: Blurriness Double vision Visual disturbance Pain

Ears/Nose/Throat/Neck: Hearing problems Ear pain Sinus problems Sore throat
 Nosebleeds

Respiratory: Shortness of breath Cough Sputum production Wheezing

Cardiovascular: Chest pain Palpitations Swelling in feet Shortness of breath during sleep
 Bleeding disorder Blood clots Fainting

Gastrointestinal: Nausea Vomiting Diarrhea Constipation Heartburn Abdominal pain

Genitourinary/Nephrology: Painful urination Blood in urine Change in urine stream
 Unusual discharge Flank pain Urinary incontinence

Musculoskeletal: Back pain Neck pain Joint pain Muscle pain Muscle cramp
 Muscle spasm Gait disturbances Joint stiffness Joint swelling Trauma

Integumentary: Rash Itching Lesions Bruising

Neurological: Abnormal balance Confusion Numbness Tingling Dizziness Headaches
 Loss of coordination Memory loss Seizures Tinnitus Tremors Vertigo

Psychiatric: Feeling anxious Depressed mood Suicidal thoughts Hallucinations
 Stress problems Suicidal planning Thoughts of harming others