Patient Name: ___________________________________ DOB: ___________________ Today's Date: _________________

NEW PATIENT MEDICAL HISTORY PACKET

First Name: ___________________**Middle Initial**____ **Last Name:** ____________________**Birth Date:** __________ **Gender: Male/Female**

Social Security #______________________**Primary Care Physician:** ___________________________ **City/State:** ____________________

Referring Physician: ____ **City, State:** ____

Preferred Pharmacy: ____**Street & City:** _____________________________________

Have you previously been seen by any of our providers or at any of our other locations? Yes No

If so, what location and which provider? ____

Brief reason for visit and explanation of your pain:
____
____

Height: _________ **Weight**___________

Have you been to the emergency room or hospitalized within the past 6 months? Yes No

1. **Allergies** - Please list all medication or latex allergies

Allergy:	Reaction:
Allergy:	Reaction:
Allergy:	Reaction:
Allergy:	Reaction:
Allergy:	Reaction:
Allergy:	Reaction:

2. **Past Medical History** - Circle ANY of the problems YOU have had

High Blood Pressure	Diabetes	Hypoglycemia	Heart Disease
Measles	Mumps	Rubella	Heart Attack
Asthma	Bronchitis	Emphysema	Tuberculosis
Stomach Ulcer	Glaucoma	Migraines/ Headache	Muscle Disease
Tissue Disease	Seizure	Stroke	Depression
Cancer	Arthritis	Polio	Constipation
Prostate Problems	Kidney Trouble	Swelling of Joints	Thyroid Disease
Bleeding Disorder	HIV/AIDS	Hepatitis	Taking Blood Thinner
Other:			

3. **Family History** - Circle ANY of the problems BLOOD relatives have had

Diabetes	Tuberculosis	Heart Disease	Vascular Disease
Fibromyalgia	Chronic Pain	Psychiatric Problems	Stroke
Drug Addiction	Lupus	Rheumatoid Arthritis	Cancer

4. **Social History**

Marital Status: Single Married Widowed Divorced Separated

Are you working? Yes No How many hours daily? 1 2 3 4 5 6 7 8 9 10

Do you smoke: Yes No If yes, pack per day? _________

Have you ever smoked in the past? Yes No

Do you drink: Yes No **How often?** Daily Weekly Occasionally Socially

TPMI TEXAS PAIN MANAGEMENT INSTITUTE

Patient Name: ___________________________________ DOB: ___________________ Today's Date: _________________

Social History Continued

Do you or have you used street drugs? Yes No -- **If Yes,** Currently **OR** In the Past

Circle any that apply: Marijuana Cocaine Amphetamine Heroin

Do you have a history of abuse with prescription drugs? Yes No

Do you have a family history of substance abuse? Yes No

If yes, circle the appropriate substance Alcohol Illegal drugs Prescription

Are your visits Workman's Compensation claims? Yes No

Are you involved in a lawsuit related to your pain condition? Yes No

Please circle an answer for **EACH** question

Do you have an Advanced Care Plan on file with PTCOA?	Yes	No	
Do you have a surrogate decision maker?	Yes	No	
Have you fallen within the last year?	Yes	No	How many times? ___________
Have you received an influenza vaccine this year?	Yes	No	
Do you currently smoke?	Yes	No	
Are you being treated for high blood pressure?	Yes	No	
Have you received a pneumonia vaccine this year?	Yes	No	

5. **Mental History**

Do you have a history of mental health disorder? Which disorder?

No Mental Disorder	Depression	Attention Deficit Disorder
Obsessive Compulsive Disorder	Bipolar Disorder	Schizophrenia

Have you ever been counseled for emotional reasons? Yes No

Do you currently take medications for mental health reasons? Yes No

Have you taken psychiatric medications in the past? Please circle all that apply.

Never taken medications for mental health reasons	Currently taking medications for mental health reasons
Have taken psychiatric medications in the past, not currently.	Admitted to hospital for mental health reasons
Never been admitted to the hospital for mental health reasons.	

Have you ever been admitted in the hospital for mental health reasons? Yes No

6. **Sexual History**

Do you have childhood or preadolescent sexual abuse? Yes No

Does your pain medication currently affect your sexual activity? (Please circle)

No	Erectile Dysfunction
Loss of interest in sexual activity due to medications	Loss of interest in sexual activity due to pain

Do you experience pain during intercourse? Yes No

TPMI TEXAS PAIN MANAGEMENT INSTITUTE

Patient Name: ___________________________________ DOB: ___________________ Today's Date: _________________

7. **Past Surgical History** - Please list all Surgeries, Dates, and Physicians

Surgery	Date	Doctor
1.		
2.		
3.		
4.		
5.		
6.		

8. **Current Medications** *(use back of page if needed)*

Medication	Dose (mg)	How often a day?
1.		
2.		
3.		
4.		
5.		
6.		

9. **Onset** - When did your pain/problem start?

Gradual	Sudden	After Fall	Motor Vehicle Accident
After Bending	While Climbing	Jumping	Lifting Weights
Playing	Running	After surgery	While walking

10. **Location -** Describe where your pain is located

____

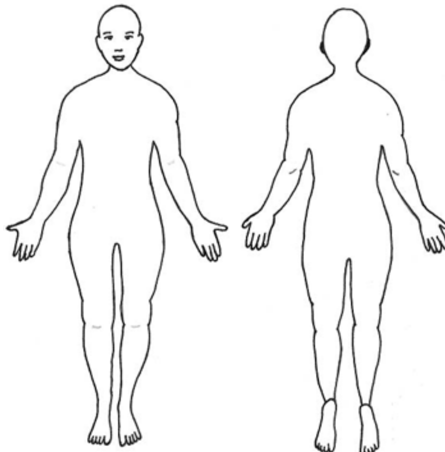
____

Duration - How long have you have had this pain?

____

____

Shade areas of Pain-



Right Left Left Right

TPMI TEXAS PAIN MANAGEMENT INSTITUTE

Patient Name: ______________________ DOB: ______________ Today's Date: ____________

11. **Frequency of Pain -** Circle ANY of the following that describe your pain

Constant with Flares	Constant	Intermittent	Rare	Seldom

12. **Pain Quality -** Circle ANY symptoms that describe your pain

Aching	Burning	Cramping	Deep
Dull	Numbness	Penetrating	Pins and Needles
Pulling	Sharp	Shooting	Spreading
Stabbing	Tender	Throbbing	Tingling
Pressure	Other:		

13. **Circle ANY area that describes where the Pain Radiates**

Pain does not radiate		Right Upper Extremity		Left Upper Extremity	
Back Side of Both Thighs		Bilateral Lower Extremities		Bilateral Upper Extremities	
Right Lower Extremity		Left Lower Extremity		Right Hand	Left Hand
Right Foot	Left Foot	Right Knee	Left Knee	Right Hip	Left Hip

14. **Pain Level** (Scale of 0-10, No pain 0 - Worst pain 10) Please list number in blank below

Worst Pain	Least Pain
Average Pain	Current Pain

15. **Worsening Factors -** Circle ANY factor that worsens your pain

Increased Activity	Bending	Coughing
Cold and Rainy Weather	Getting up from sitting/lying position	Housework
Lifting	Looking Up	Looking Down
Lying Flat on Back	Lying Flat on Stomach	Pressure Changes
Sitting	Standing	Sometimes No Reason
Turning Head from Side to Side	Walking	

16. **Relieving Factors -** Circle ALL that make your pain better

Changing Position	Cold Pack	Exercise
Heating Pad	Injections	Lying Down
Lying Flat	Massage	Medications
Rest	Sitting	Sometimes Nothing Helps
Standing	Walking	Other:

17. **Associated Symptoms -** Circle ALL symptoms you have when you are in pain

Dependence on others for activities	Depression	Difficulty carrying out certain activities
Difficulty staying asleep due to pain	Falling Frustration	Frustration
Numbness	Recent fever, chills, or sweats	Weakness

TPMI TEXAS PAIN MANAGEMENT INSTITUTE

Patient Name: ________________________________ DOB: _________________ Today's Date: ________________

18. **Do you have side effects from current medications?** Yes No If so, List: _______________

19. **Treatment History -** Circle ALL Caregivers you have visited.

Family Physician	Physical Therapist	Pain Medicine Doctor	Spine Surgeon
Neurologist	Rheumatologist	Chiropractor	Orthopedist
General Surgeon	Acupuncturist	Podiatrist	Psychiatrist
Urologist	Endocrinologist	Oncologist	None of these

20. **When was prior treatment started?**

When the home remedies and other OTC did not work	A couple of days before onset	Immediately after pain started	Immediately after injury	After a few months wait

21. **Previous Tests Performed -** Circle ALL that apply

MRI	CT scan	X-Rays	EMG Test
Discogram	Myelogram	Bone Scan	Nerve Conduction Study
EEG	Rheumatologist panel	Neuropathy Panel	EKG
Lumbar Puncture	HIV/ Aids	Ultrasound	No Testing

22. **Please Circle ANY medications below that you have taken in the past regarding your pain**

NSAIDS (Ibuprofen, Tylenol, Naproxen, etc)	Celebrex	Skelaxin	Soma	Robaxin
Flexeril	Zanaflex/Tizanidine	Diclofenac/Mobic/ Flector Patches	Baclofen	Gabapentin/ Horizant
Lyrica	Amitriptyline	Topamax	Relpax	Depakote
Wellbutrin	Zoloft	Paxil	Prozac	Cymbalta
Savella	Fioriciet/ Fiorinal	Imitrex	Ultram/ Tramadol	Hydrocodone
Oxycodone	Fentanyl/Actiq	Hydromorphone	Oxycontin	MS-Contin
Morphine	Nucynta	Opana	Methadone	Butrans Patch
Stadol	Medrol Dose Pack/ Steroids	Colace	Dulcolax	Miralax

23. **Please Circle ALL treatments you have received**

Acupuncture	Celiac Plexus Block	Discography	Epidural Blood Patch	Epidural Steroid Injection
Facet Injection	Genicular Nerve Block	Heat	Home Exercise	Ice
Intrathecal infusion pump	Intercostal Nerve Block	Joint Injection	Lumbar sympathetic block	Massage
Muscle/ Trigger Point Injection	Occipital Nerve Block	Physical Therapy	Radiofrequency Ablation	Sacroiliac Joint Injection
Spinal Cord Trial	Spinal cord stimulator permanent	Stellate Ganglion Block Surgery	TENS Unit	Vertebroplasty/ Kyphoplasty

TPMI TEXAS PAIN MANAGEMENT INSTITUTE

Patient Name: ______________________________ DOB: ________________ Today's Date: _______________

24. **Please answer the following questions as honestly as possible, there are no wrong answers.**

SOAAP-R	Never	Seldom	Sometimes	Often	Very Often
How often do you have mood swings?	*	*	*	*	*
How often have you felt a need for higher doses of medication to treat your pain?	*	*	*	*	*
How often have you felt impatient with your doctors?	*	*	*	*	*
How often have you felt that things are just too overwhelming that you can't handle them?	*	*	*	*	*
How often is there tension at home?	*	*	*	*	*
How often have you been concerned that people will judge you for taking pain medication?	*	*	*	*	*
How often do you count pain pills to see how many are remaining?	*	*	*	*	*
How often do you feel bored?	*	*	*	*	*
How often have you taken more pain medication that you were supposed to?	*	*	*	*	*
How often have you worried about being left alone?	*	*	*	*	*
How often have you felt a craving for medication?	*	*	*	*	*
How often have others expressed concern over your use of medication?	*	*	*	*	*
How often have any of your close friends had a problem with drugs/alcohol?	*	*	*	*	*
How often have others told you that you had a bad temper?	*	*	*	*	*
How often have you felt consumed by the need to get pain medication?	*	*	*	*	*
How often do you run out of pain medication?	*	*	*	*	*
How often have others kept you from getting what you deserve?	*	*	*	*	*
How often, in your lifetime, have you had legal problems or been arrested?	*	*	*	*	*
How often have you attended an AA or NA meeting	*	*	*	*	*
How often have you been in an argument that was so out of control that someone got hurt?	*	*	*	*	*
How often have you been sexually abused?	*	*	*	*	*
How often have others suggested that you have a drug or alcohol problem?	*	*	*	*	*
How often have you had to borrow pain medications from family or friends?	*	*	*	*	*

Patient Name: ______________________________ DOB: ________________ Today's Date: ______________

25. **<u>Review of Systems -</u>** Circle ANY of the symptoms you have had recently

Cardiovascular	Chest Pain	Irregular Heartbeat	Shortness of breath	Pedal Edema			
Constitutional	Fever	Weight Gain	Weight Loss	Poor Appetite	Sleep Difficulty	Fatigue/ Tiredness	
Endocrine	Excessive Thirst	Heat or Cold Intolerance	Erectile Dysfunction	Thyroid Trouble	Loss of Sexual Desire		
Eyes	Blurred vision	Double Vision	Eye Pain				
Gastrointestinal	Abdominal Pain	Nausea	Vomiting	Diarrhea	Constipation		
Genitourinary	Urinary Incontinence	Pain during urination	Kidney Stones	Difficult to start urination	Urinary Retention		
HEENT	Dizziness	Hoarseness	Ear Pain				
Hematologic	Abnormal Bleeding	Bleeding Disorder	Easy Bruising				
Musculoskeletal	Muscle Cramp	Neck Pain	Loss of Bulk Muscle	Back Pain	Joint Pain	Joint Stiffness	Joint Swelling
	Arthritis	Limitation of Joint Movement	Muscle Tenderness/ Pain				
Neurological	Headache	Numbness	Arm Weakness	Leg Weakness	Generalized Weakness	Tremors	Trouble with Memory
	Trouble with Concentration	Unsteady Walk	Stroke	Epilepsy. Seizures	Sedation	Spasticity	
Psychological	Depression	Anxiety	Panic Attack	Suicidal Ideation			
Respiratory	Trouble Breathing	Snoring	Trouble breathing during sleep	Cough	Wheezing	Congestion	
Skin	Rashes	Ulcers	Infection	Color Changes	Hypersensitivity		