

*****Ask pt if they have had any surgery/procedures /tests (MRI. Labs, etc) since last visit, if yes then call for documents/results. Yes/No Initials ____**

Name: _____ DOB: ____/____/____ Age: ____ Today's date: _____

- Name of your current Family Physician _____
- The doctor you want your office note sent to (*first and last name*) _____ (City) _____
- What is your occupation _____ Are you currently working? _____
- Are you on a blood thinner? (coumadin, plavix, etc) _____
- Do you take Aspirin, Aleve, Naproxen or aspirin containing products? _____ if yes, how often? _____
- List **ALL** your medications, include over the counter, vitamins herbal supplements etc.

Medication	strength	How many at one time?	How many times do you take it per day?	Date of last dose	Time of last dose

7. Place an X on the line that best describes the severity of your pain over the last month:
 No Pain _____ Worst possible pain _____

8. Describe the pain (*constant, sharp, dull, achy, burning, numbness*) _____

10. How long have you had this pain? _____

11. Does anything make the pain worse? _____ If yes what? _____

12. Does anything make the pain better? _____ If yes what? _____

13. Have you noticed any associated problems? _____

14. Has there been a change in your physical status or pain since your last visit? ____

If yes, what? _____

15. Do you have a pacemaker or ICD? Yes ____ No ____

16. How many hours(total) do you sleep at night? ____ Number of times you wake up because of your pain ____.

17. Are you currently engaged in any regular physical activity or physical therapy? _____

18. Have you tried psychological intervention or biofeedback? _____ If yes did it help? ____

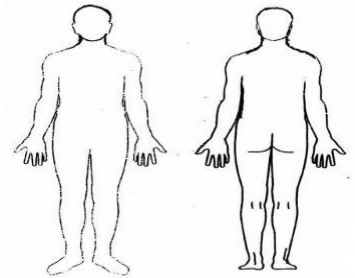
19. Have you tried a TENS unit or an IF-2? ____ If yes how much does it help? _____

20. If you had a recent block, how much did it help? _____

21. Do you use alcohol? _____ (drinks per week), or smoke _____ (pack per day)

9. Where is your pain located?

R Front L L Back R



System	No	Yes	If yes, please explain problem
Fever, Weight loss			
Vision Problems			
Ear, nose, throat, mouth			
Chest pain, short of breath, palpitations			
Swelling in feet or ankles, etc			
Cough, wheezing			
Constipation, diarrhea, abdominal pain			
Urinary/genital problems			
Musculoskeletal problems			
Skin changes, problems			
Fainting, dizziness			
Depression, change in mood			
Hormonal			
Anemia, Swollen lymph nodes			
Allergies, immune problems, latex allergy			

22. Do you use illicit substances?
 (*marijuana, cocaine, etc*) _____

23. Is there a chance you are pregnant? Yes ____ No ____
IF YES PLEASE ALERT THE NURSE!