

History Form - New Patient

HISTORY - COMPLETED BY PATIENT

Name: _____

Date: _____

1. Reason for your visit today _____ Primary Care MD/provider: _____

2. Please indicate if you are having any current problems or symptoms in any of the following areas:

- | | |
|---|---|
| <input type="checkbox"/> General (fever, fatigue, wt change, etc) | <input type="checkbox"/> Back or leg pain |
| <input type="checkbox"/> Eyes, ears, nose or throat | <input type="checkbox"/> Nerve: numbness, paralysis |
| <input type="checkbox"/> Skin rash, skin lesions | <input type="checkbox"/> Bladder/Urinary problem |
| <input type="checkbox"/> Dizziness, fainting, irreg heart beat | <input type="checkbox"/> Diabetes, thyroid disorder |
| <input type="checkbox"/> Cough, chest pain, shortness of breath etc | <input type="checkbox"/> Depression, anxiety, bipolar |
| <input type="checkbox"/> Nausea, abdom. pain, diarrhea etc | <input type="checkbox"/> Sleep apnea, sleep disorder |
| <input type="checkbox"/> Liver or kidney problem | <input type="checkbox"/> Abnormal blood tests |
| <input type="checkbox"/> Muscles/Joints: pain, swelling | <input type="checkbox"/> Other |

Comments:

reviewed per MD

3. Medication(s) OR: if have list, check and attach

4. Previous (major) surgeries and approx date:

5. Allergic to any medication (Penicillin, Sulfa, etc)?

6. Social History

If working outside the home, please tell me briefly, what you do: _____

- Are you currently in a "long-term relationship" with someone? yes no Do you live alone: yes no
- Do you **exercise**, for its own sake? _____ times/week What is your favorite hobby/recreational activity? _____
- Have you **ever** been treated for alcohol or substance abuse? yes no Do you see a personal counselor or therapist? _____ AA/NA? _____
- If you now smoke, or have smoked cigarettes, for how many years? _____
- My *average* alcohol intake is: _____ (glasses/drinks) _____ per day _____ per week _____ per month
- Do you use marijuana regularly? yes no Do you have a medical MJ authorization? yes no

StatCare

Name: _____ Date: _____

<u>Medical History</u> <i>have you ever had any of the following:</i>	<u>Family History</u>
<p><u> </u> <i>Arthritis</i></p> <p><u> </u> Osteoarthritis</p> <p><u> </u> Rheumatoid</p> <p><u> </u> Allergies (Seasonal, Etc.)</p> <p><u> </u> Asthma</p> <p><u> </u> Bleeding problem</p> <p><u> </u> Blood clots</p> <p><u> </u> Blood transfusion</p> <p><u> </u> COPD/emphysema</p> <p><u> </u> Fracture: _____</p> <p><u> </u> Fibromyalgia</p> <p><u> </u> <i>Headache</i></p> <p><u> </u> Migraine <u> </u> Tension</p> <p><u> </u> <i>Cancer:</i></p> <p>Site/type _____</p> <p><i>Heart disease:</i></p> <p><u> </u> Coronary Heart Disease</p> <p><u> </u> Angioplasty or bypass (yr) _____</p> <p><u> </u> Congestive Heart Failure</p> <p><u> </u> Heart valve problems</p> <p><u> </u> High Blood Pressure</p> <p><u> </u> tachycardia or atrial fibrillation</p> <p><u> </u> Ulcers</p> <p><u> </u> GERD/hiatal hernia/reflux</p> <p><u> </u> Hepatitis/Jaundice</p> <p><u> </u> Colitis, Polyps, Irritable Bowel</p> <p><u> </u> Kidney/Bladder: _____</p> <p><u> </u> Abnormal PAP smear</p> <p><u> </u> Back problems, sciatica or rupt. Disc</p> <p><u> </u> Bipolar disorder</p> <p><u> </u> Anxiety or Panic Attacks</p> <p>Other: _____</p> <p><u> </u> Seizures/Epilepsy</p> <p><u> </u> Stroke</p> <p><u> </u> Sleep Apnea (not insomnia)</p> <p><u> </u> Thyroid (high/low)</p> <p><u> </u> Tuberculosis (positive TB test)</p> <p>Other: _____</p> <p><u> </u> Anemia</p> <p><u> </u> Diabetes</p> <p><u> </u> Eating disorder</p> <p><u> </u> High Cholesterol/Triglycerides</p> <p><u> </u> Gout</p> <p><u> </u> Osteoporosis</p> <p><u> </u> <i>Strict</i> vegetarian (no meat)</p>	<p><i>Anyone in your IMMEDIATE family have:</i></p> <p><i>Use this format:</i></p> <p><i>F = father</i></p> <p><i>M = mother</i></p> <p><i>S = sibling (brother/sister)</i></p> <p>_____ Cancer (type) _____</p> <p>_____ High Blood Pressure</p> <p>_____ Coronary Heart Disease</p> <p>_____ Heart Attack - age _____</p> <p>_____ Stroke</p> <p>_____ Other vascular disease</p> <p>_____ Diabetes</p> <p>_____ Fibromyalgia</p> <p>_____ Alcohol/Substance Abuse</p> <p>_____ Bipolar</p> <p>_____ Colonic Polyps</p> <p>_____ Thyroid disease</p> <p>Other: _____</p> <p>_____</p> <p><u>Date</u> <u>When was your last:</u></p> <p>_____ Physical with blood work</p> <p>_____ Pap Smear</p> <p>_____ Mammogram</p> <p>_____ Prostate/digital rectal exam/PSA</p> <p>_____ Colorectal cancer screening (Colonoscopy)</p>

Consultation: Chronic Pain

Name: _____ Date: _____

The physician who most recently helped manage my pain condition:

Name: _____

Treatments in current use or tried in the past (**circle** if treatment helpful, **cross out** if not helpful):

Physical therapy, Massage or chiropractic, acupuncture, TENS, spinal cord stimulator

Antidepressants, muscle relaxers (flexeril, soma, robaxin, zanaflex, valium), anti-inflammatories (ibuprofen, naproxen, celebrex etc)

Injections: Spinal, trigger point

Neurontin (gabapentin), Lyrica, nortriptyline, amitriptyline, Effexor (venlafaxine), Cymbalta,

Savella, Topamax, Depakote

Methadone, Morphine, Oxycodone, Oxycontin, Opana, Nucynta, Suboxone (buprenorphine), Oxycontin, Fentanyl (Duragesic patch), Dilaudid (hydromorphone), Hydrocodone (Vicodin), Tramadol (Ultram)

I have seen a specialist in:

Orthopedic surgery:

Pain management:

Neurology or Rheumatology:

Neurosurgery:

Have you ever had a DUI, been treated for drug or alcohol addiction?

(A history of chemical addiction is not necessarily a contraindication against pain medication treatment, but must be taken into account in the treatment plan.) YES NO

Signature: _____

DRUG USE QUESTIONNAIRE (DAST-20)

Name: _____ Date: _____

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question.

In the statements "drug use" refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

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For information on the DAST, contact Dr. Harvey Skinner at the Addiction Research Foundation, 33 Russell St., Toronto, Canada, M5S 2S1.

These questions refer to the past 12 months.

Circle your
response

1. Have you used drugs other than those required for medical reasons?..... Yes No
2. Have you abused prescription drugs? Yes No
3. Do you abuse more than one drug at a time? Yes No
4. Can you get through the week without using drugs? Yes No
5. Are you always able to stop using drugs when you want to?..... Yes No
6. Have you had "blackouts" or "flashbacks" as a result of drug use? Yes No
7. Do you ever feel bad or guilty about your drug use? Yes No
8. Does your spouse (or parents) ever complain about your involvement
with drugs? Yes No
9. Has drug abuse created problems between you and your spouse
or your parents? Yes No
10. Have you lost friends because of your use of drugs? Yes No
11. Have you neglected your family because of your use of drugs? Yes No
12. Have you been in trouble at work because of drug abuse? Yes No
13. Have you lost a job because of drug abuse? Yes No
14. Have you gotten into fights when under the influence of drugs? Yes No
15. Have you engaged in illegal activities in order to obtain drugs? Yes No
16. Have you been arrested for possession of illegal drugs? Yes No
17. Have you ever experienced withdrawal symptoms (felt sick) when you
stopped taking drugs? Yes No
18. Have you had medical problems as a result of your drug use
(e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?..... Yes No
19. Have you gone to anyone for help for a drug problem? Yes No
20. Have you been involved in a treatment program specifically
related to drug use? Yes No

NAME: _____

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How often have you felt a need for higher doses of medication to treat your pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. How often have you felt impatient with your doctors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. How often have you felt that things are just too overwhelming that you can't handle them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. How often is there tension in the home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. How often have you counted pain pills to see how many are remaining?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. How often have you been concerned that people will judge you for taking pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. How often do you feel bored?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. How often have you taken more pain medication than you were supposed to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. How often have you worried about being left alone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. How often have you felt a craving for medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. How often have others expressed concern over your use of medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. How often have others told you that you had a bad temper?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. How often have you felt consumed by the need to get pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. How often have you run out of pain medication early?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. How often have others kept you from getting what you deserve?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. How often, in your lifetime, have you had legal problems or been arrested?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. How often have you attended an AA or NA meeting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. How often have you been in an argument that was so out of control that someone got hurt?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. How often have you been sexually abused?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. How often have others suggested that you have a drug or alcohol problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. How often have you had to borrow pain medications from your family or friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. How often have you been treated for an alcohol or drug problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*Please include any additional information you wish about the above answers.
Thank you.*

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