QUALITY OF LIFE MEDICAL CENTERS

Interventional Pain Management

Jared Gilman, M.D.

PATIENT INFORMATION

MRN: _____
FOR OFFICE USE ONLY

Today's date: _____

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

Referring Physician: _____ Primary Care Physician_____

Pharmacy Name & Address: _____

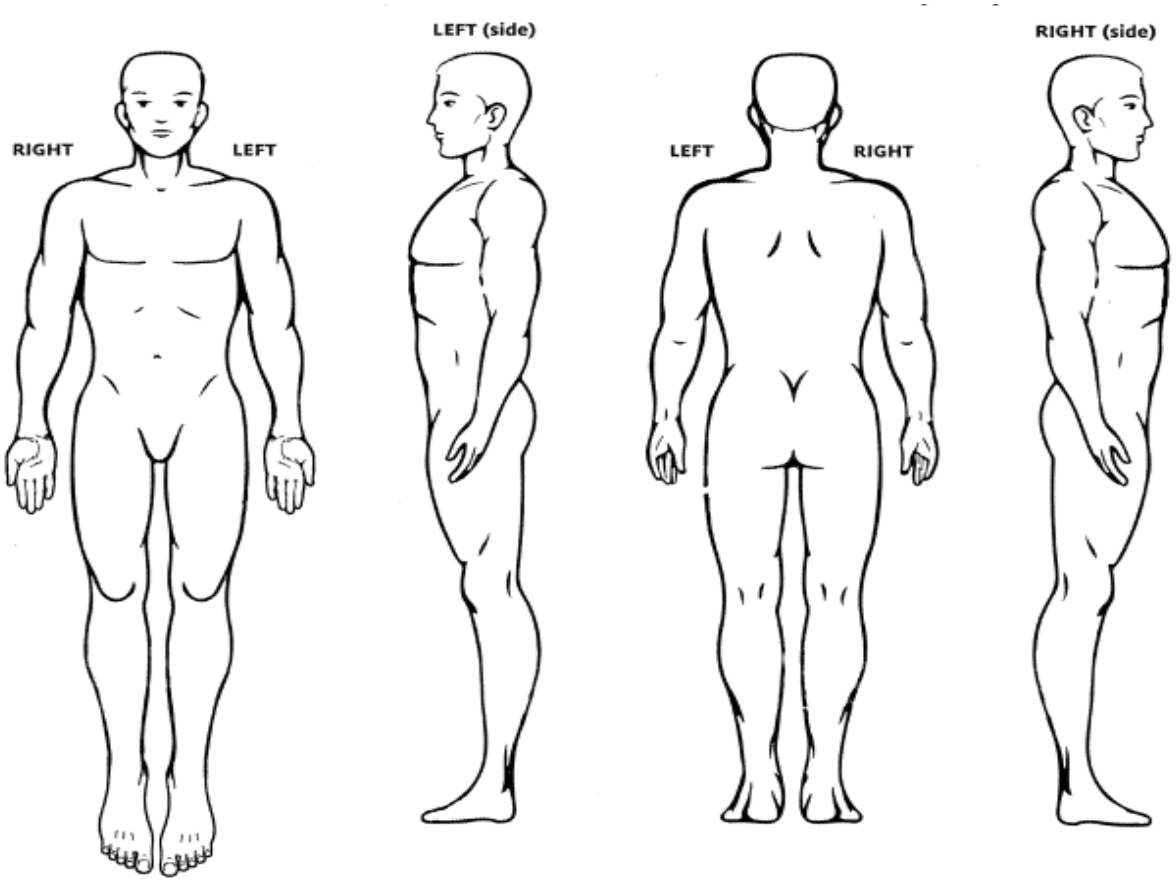
PAIN HISTORY

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/shade the area(s) of your pain:



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ONSET OF SYMPTOMS

Approximately when did this pain begin? _____

What do you think caused you current pain? _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since you pain began, has you pain ☐ Increased ☐ Decreased ☐ Stayed the same

Is your pain the result of a Motor Vehicle Accident or Personal Injury? ☐ Yes ☐ No
(Personal injury: legal term describing injury sustained to your person by negligence of another)
Is there a legal case pending regarding your pain? ☐ Yes ☐ No

Is this a work related injury? ☐ Yes ☐ No

PAIN DESCRIPTION

What number on the scale describes your **pain right now?** 0 1 2 3 4 5 6 7 8 9 10

What number on the scale describes your **worst pain?** 0 1 2 3 4 5 6 7 8 9 10

What number on the scale describes your **least pain?** 0 1 2 3 4 5 6 7 8 9 10

Check all the following that describe your pain:

☐ Aching	☐ Hot/Burning	☐ Shooting	☐ Stabbing/Sharp
☐ Cramping	☐ Numbness	☐ Spasming	☐ Throbbing
☐ Dull	☐ Shock-like	☐ Squeezing	☐ Tingling
☐ Pins & Needles	☐ Other _____		

What word best describes the frequency of your pain? ☐ Constant ☐Intermittent ☐Worsens through the day

When is your pain at its worst? ☐ Mornings ☐During the day ☐Evenings

PAIN FACTORS

What makes your pain **worse?** (mark all that apply)

☐ Sitting	☐ Twisting	☐ Sneezing	☐ Laying Down	☐ Bending
☐ Driving	☐ Standing	☐ Lifting	☐ Coughing	☐ Walking

☐ Other: _____

What makes your pain **better?** (mark all that apply) ☐ Rest ☐ Bending ☐ Medications ☐ Heat
☐Laying Down ☐ Sitting ☐ Ice ☐ Other_____

DIAGNOSTIC TESTS & IMAGING

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

☐ MRI of the _____ Date: _____ Facility: _____
☐ X-ray of the _____ Date: _____ Facility: _____
☐ CT Scan of the _____ Date: _____ Facility: _____
☐ EMG/NCV Study of the _____ Date: _____ Facility: _____
☐ Other diagnostic testing: _____

PAIN TREATMENT HISTORY

Mark all the following pain treatments you have undergone prior to today's visit:

☐ Chiropractic ☐ Psychological Therapy
☐ Physical Therapy *Dates and number of sessions*: _____
☐ Pain Injections *Dates and name of procedures*: _____
☐ Other Pain Treatments: _____

MEDICATIONS

Please list all **Pain Medications** you are currently taking: _____

_____

Please list all **Pain Medications** that you have tried **in the past:**

_____

Do you take any **Blood-Thinners?** ☐ Yes ☐ No
☐ Plavix/Clopidogrel ☐ Coumadin/ Warfarin ☐ Apixaban/Eliquis ☐ Pradaxa ☐ Heparin ☐ Lovenox
☐ Other: _____

Do you take any **NSAIDs** (Aspirin, Ibuprofen, Naproxen, etc)? ☐ Yes ☐ No
If YES, do they help with your pain? ☐ Yes ☐ No

Please list the NSAID you take with dose and frequency: _____

ALLERGIES

Please list any **Medication Allergies:** _____

_____

Topical Allergies: ☐ Iodine ☐ Latex ☐ Tape
Do you have any allergies to **IV Contrast?** ☐ Yes ☐ No If yes, please describe your reaction to IV Contrast:

_____

☐ **I HAVE NO KNOWN ALLERGIES**

_____

PAST MEDICAL HISTORY

Are you currently pregnant? ☐ Yes ☐ No Are you post-menopausal? ☐ Yes ☐ No

Mark all conditions/diseases that you have been **diagnosed** with:

☐ Asthma ☐ Heart Disease ☐ Migraines
☐ Cancer, Type _____ ☐ Hepatitis, Type _____ ☐ Osteoarthritis/Osteoporosis
☐ Diabetes, Type _____ ☐ HIV/AIDS ☐ Peripheral Vascular Disease
☐ Emphysema/COPD ☐ High Blood Pressure ☐ Shingles
☐ Epilepsy ☐ Kidney Disease ☐ Sleep Apnea
☐ Fibromyalgia ☐ Lupus ☐ Stroke
☐ Other _____

☐ **I HAVE NO SIGNIFICANT MEDICAL HISTORY**

PAST SURGICAL HISTORY

Do you currently have an implanted ICD, pacemaker or defibrillator? ☐ Yes ☐ No

Please list any surgeries related to the area of your pain: _____

_____

Please list any other surgeries: _____

_____

☐ **I HAVE NO SIGNIFICANT SURGICAL HISTORY**

FAMILY HISTORY

Mark all appropriate diagnose as they pertain to your **biological** family members:

☐ Anxiety/Depression ☐ Diabetes ☐ High Blood Pressure ☐ Rheumatoid Arthritis
☐ Arthritis ☐ Headaches ☐ Kidney Problems ☐ Seizures
☐ Cancer ☐ Heart Disease/Stroke ☐ Liver Problems ☐ Substance Abuse

☐ **I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY** ☐ **I AM ADOPTED** (No medical history available)

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No If yes, please explain _____
Do you drink Alcohol? ☐ Yes ☐ No If yes, please explain_____
Illegal Drugs: ☐ Yes ☐ No ☐ Never used
☐ Current Use (list) _____
☐ Former Use (list) _____
Highest level of education: _____
Employment: ☐ Yes ☐ No ☐ Retired ☐ Disabled If yes, what is your occupation? _____
Do you exercise on a regular basis? ☐ Yes ☐ No
If YES, how often: _____

REVIEW OF SYSTEMS

Mark all the following symptoms that you **currently** suffer from:

Constitutional:
- ☐ Chills
- ☐ Difficulty Sleeping
- ☐ Fatigue
- ☐ Fevers
- ☐ Night Sweats

Cardiovascular/Respiratory:
- ☐ Chest Pain
- ☐ Cough
- ☐ Difficulty Breathing
- ☐ Fainting
- ☐ High Blood Pressure
- ☐ Swelling in the Feet

Gastrointestinal:
- ☐ Constipation
- ☐ Dark & Tarry Stool
- ☐ Diarrhea
- ☐ Nausea/Vomiting

Genitourinary/Nephrology
- ☐ Blood in the Urine
- ☐ Involuntary Urination
- ☐ Loss of Bowel Control
- ☐ Painful Urination
- ☐ Pelvic Pressure

Ear/Nose/Throat/Neck
- ☐ Difficulty Hearing
- ☐ Earaches
- ☐ Hay fever/Allergies
- ☐ Nosebleeds
- ☐ Recurrent Sore Throats
- ☐ Ringing in the Ears
- ☐ Sinus Problems

Eyes:
- ☐ Recent Visual Changes

Neurological:
- ☐ Dizziness
- ☐ Headaches
- ☐ Instability When Walking
- ☐ Numbness/Tingling
- ☐ Weakness

Psychiatric:
- ☐ Anxiety/Stress
- ☐ Depressed Mood
- ☐ Suicidal Thoughts
- ☐ Suicidal Planning

Musculoskeletal:
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Neck Pain

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____