University of Arizona Medical Center
Pain Clinic

GENERAL INFORMATION

NAME:_____

ADDRES:_____

HOME PHONE:_____CELL PHONE:_____

DATE OF BIRTH:_____

REFERRING PHYSICIAN: Dr. _____

ADDRESS:_____

PHONE:_____

PRIMARY CARE PHYSICAIN (if different from referring physician):

Dr._____

ADDRESS:_____

PHONE:_____

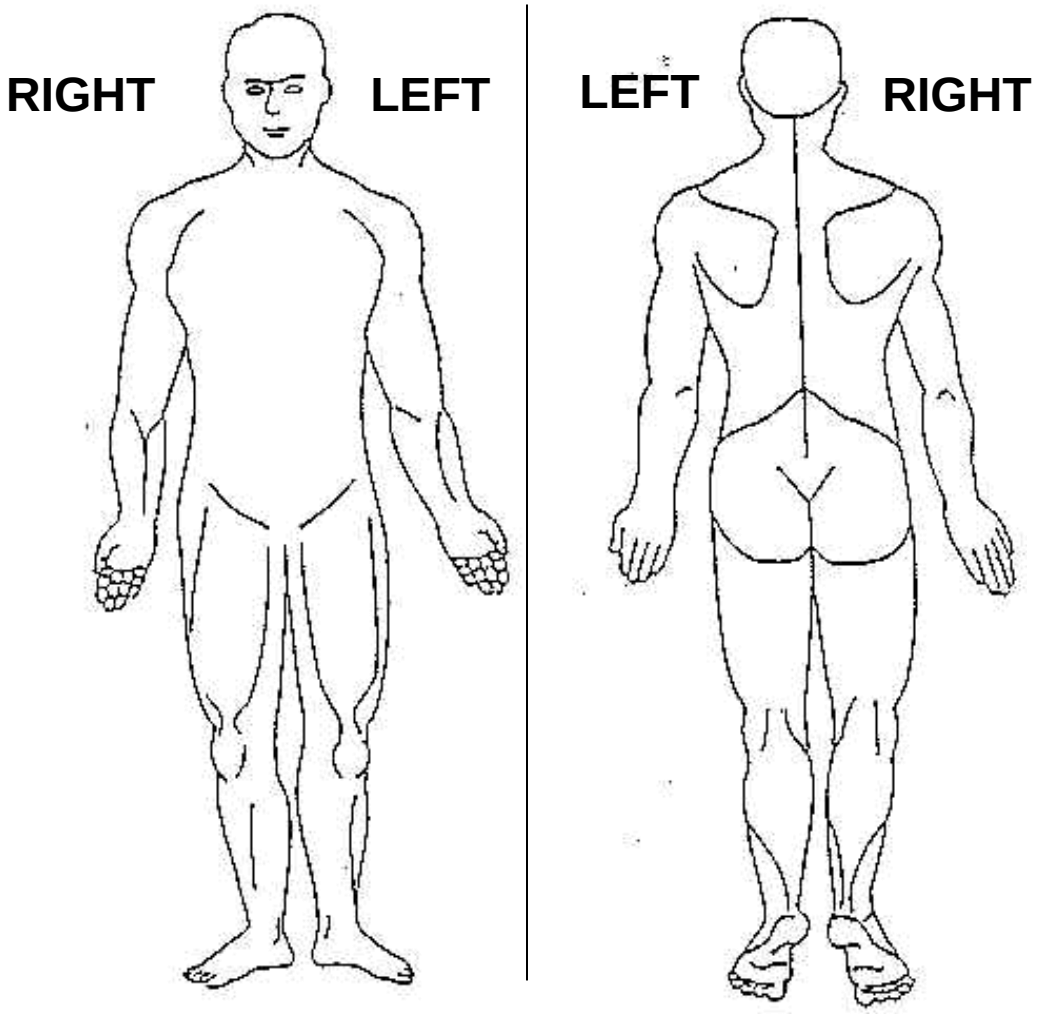
PHARMACY:_____

ADDRESS:_____

PHONE:_____

WHERE IS YOUR PAIN

Please shade the areas of your pain in the diagrams below.



DESCRIBE YOUR PAIN SYMPTOMS

When did your pain first start?_____

Where is your pain?_____

_____

What do you think is causing your pain?_____

_____

Did your pain begin with an injury? No/Yes

If you were injured, did the injury occur at work/in a motor vehicle accident/others.

Please explain how you were injured:_____

_____

Do you have a legal case pending regarding your pain: No/Yes

Please rate your pain on a scale from 0 (no pain) to 10 over last month(the most severe pain you can imagine)

How severe is your pain at its WORST:_____/10

How severe is your pain at its BEST:_____/10

What is the pain on AVERAGE: _____/10

What is your pain level TODAY: _____/10

What does your pain feel like (please circle all that apply)

Throbbing/ Shooting/ Stabbing/ Burning/ Sharp/ Tingling/ Numb/ Tender/

Pressure/ Deep/ Aching/ Cramping/ Heaviness.

Other:_____

What is the pattern of your pain? Continuous (always present)/ Comes and goes

Gets worse as the day goes on.
What makes your pain worse? Sitting/ Bending/ Lifting/ Twisting/ Driving/

Coughing/ Sneezing/ Standing/ Walking/ Lying down
Other, explain:_____

What makes your pain better? Rest/ Lying down/ Bending/ Sitting/ Medications/ Ice/ Heat

Others, specify:_____

Dose your pain interfere with any of the following? (Check all that apply)

Sleep/ Daily activity/ Work/ Relationships.

Dose your pain make you feel (check all that apply)

Depressed/ Angry/ Frustrated/ Helpless/ Hopeless

Please check any previous treatment you have had for your current pain:

Herbal remedies:_____ Any benefit?_____

Physical or occupational therapy: _____ When was the last session?_____

How long did therapy last? _____Any benefit?_____

Chiropractor visit: _____ When was last visit?_____ Any benefit?_____

Did you see a pain doctor? : _____

Injections?_____ Where?_____

When?_____ Any benefit?_____

Who did them?_____

Surgery?_____ Any benefit?_____

Biofeedback:_____ Any benefit?_____

Acupuncture:_____ Any Benefit?_____

List any tests you have had related to your current pain:

X-ray/ CT scan/ MRI/ Myelogram/ Bone scan/ EMG/ Blood tests.

PAST MEDICAL PROBLEMS

Have you ever had any of the following conditions (check all that apply)

Diabetes/ Bleeding disorder/ Heart murmur/ Rheumatic fever/ HIV or AIDS/ Stroke/ Heart attack/ Heart problem/ Aneurysm/ Circulation problem/ High cholesterol/ Seizures/ Cancer/ Kidney Problems/ High blood pressure/ Respiratory problems/ Thyroid problems/ Ulcers/ Liver problem/ Heartburn/ Pacemaker/ Hepatitis/ Asthma/ Sleep apnea/ Defibrillator/ Fibromyalgia

Other:_____

PAST SURGERIES

Please list all surgeries you had and their approximate date.

_____
_____
_____
_____
_____
_____

ALLERGIES AND MEDICATIONS

Allergies and intolerances: (Please list all allergies or intolerances)

_____

_____

CURRENT pain medications (please indicate dosage and frequency and indicate if they help or not)

_____

Previous pain medications (please indicate dosage and frequency and indicate if they help or not)

_____

_____

Other medications (please indicate dosage and frequency)

_____

_____

Are you currently taking any blood thinner medications: **Yes/ No**. _____

FAMILY HISTORY

Does anyone in your family suffer from chronic illness? No/ Yes
Relationship (e.g. father, sister, etc.) Illness

_____

_____

SOCIAL HISTORY

What was the highest level of education you completed?
High school/ College/ Graduate school

What is your marital status
Single/ Married/ Separated/ Divorced/ Widowed

How many children do you have?_____

Do/did you smoke? No/ Yes
If yes, how many packs/day_____ How many years have you smoked?_____

Do/did you drink alcohol? No/ Yes
If yes, how much and often do you drink? (e.g. 2 glasses of wine/day)_____
Do/did you use recreational drugs? No/Yes. If yes, please explain_____

Do you exercise on regular basis? No/ Yes. If yes, how often?_____

WORK HISTORY

Are you currently working? No/ Yes. If yes, who is your current employer_____
_____

What is your occupation?_____

Are you on disability? No/Yes. If yes, how long have you been disabled?_____
What caused you to become disabled?_____

PSYCHOSOCIAL HISTORY

Have you ever been treated for emotional or behavioral disorder? No/Yes? If yes,

please explain:_____

Have you ever been treated for depression? No/Yes. If yes, when?_____

Have you ever attempted suicide? No/Yes. If Yes, when?_____

Do you currently have suicide thoughts? No/Yes

REVIEW OF SYSTEM

Please circle any of the following problems that you are now experiencing:

Constitutional: Weight change/ Weakness/ Fatigue/ Fever.
Eyes, Nose, Throat: Hearing loss/ Nasal congestion/ Ringing in your ears/ Dizziness/ Sore throat.
Cardiovascular: Shortness of breath/ Chest pain/ palpitations/Ankle swelling.
Respiratory: Cough/ Sputum/ Coughing up blood/ Difficulty breathing/Wheezing.
Gastrointestinal: Heartburn/ nausea/ vomiting/ abdominal pain/ constipation/ diarrhea/ bowel incontinence/ bloody stool.
Genitourinary: pain with urination/ bladder incontinence/ urgency/ blood in urine.

Musculoskeletal: Joint pain/ Stiffness/ Neck or back pain.
Skin: Rash/ Lumps/ Itching/ Hair changes/ Nail changes.
Neurological: Headache/ Weakness/ Numbness/ Seizures/ Blackouts/ Memory loss.
Psychological: Nervousness/ Tension/ Depression/ Anxiety.
Endocrine: Heat / cold intolerance/ Sweating/ Thirst/ Hunger/ Change in urination.
Hematologic: Bruising/ Bleeding.
Is there any chance you could be pregnant? No/Yes.

OPIOID SCREENING

		Mark if applies
Family history of substance abuse	1. Alcohol 2. Illegal drugs 3. Prescription drugs	☐ ☐ ☐
Personal history of substance abuse	1. Alcohol 2. Illegal drugs 3. Prescription drugs	☐ ☐ ☐
Age (Mark box if between 16-45 year old)		☐
History of preadolescence sexual abuse		☐
Psychological Disease	1. Attention-Deficit/Hyperactivity Disorder; Obsessive Compulsive Disorder; Bipolar Disorder; Schizophrenia 2. Depression	☐ ☐

OSA SCREENING

1. **Snoring:** Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? **Yes /No**
2. **Tired:** Do you often feel tired, fatigued, or sleepy during daytime? **Yes /No**
3. Observed: Has anyone observed you stop breathing during your sleep? **Yes/No**
4. **Blood pressure:** Do you have or are you being treated for high blood pressure? **Yes /No**
5. **BMI:** BMI more than 35 kg/m2? **Yes/No**
6. **Age:** Age over 50 yr old? **Yes/No**
7. **Neck circumference:** Neck circumference greater than 40 cm? **Yes/No**
8. **Gender:** Gender male? **Yes/No**

I, the undersigned, have completed this form to the best of my knowledge. The information that I have provided is true and accurate to the best of my knowledge.

_____ _____

Patient/ Guardian signature Date