Holland Hospital

PAIN MANAGEMENT

Patient Health History

Please use blue or black ink only

Patient: _____ Date of Birth.: _____ Date: _____

Sex: M F Height: _____ Weight: _____ Handedness: R L

Primary Care Physician: _____ Referring Physician: _____

What problem brought you to our office today?

_____

_____

How long have you had this problem? (Specify date of injury) _____

How often does it occur? _____

Is your problem related to work or an auto accident? If so, when? _____

Can you describe your symptoms? (aching, sharp, stabbing,etc)

_____

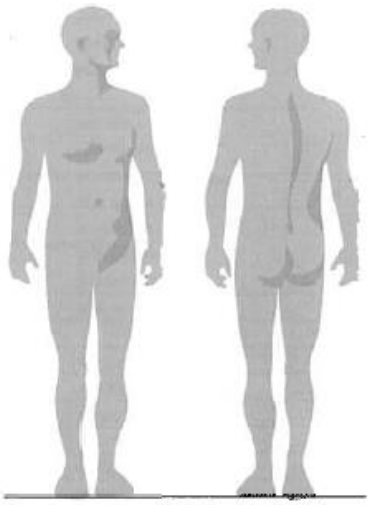
_____

What makes your symptoms worse?

_____

What makes your symptoms better?

_____



Circle the area above that is painful
Shade areas of numbness or tingling

Circle the number that best describes your current pain level.

no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain N/A

What treatments have you already attempted?

	Effective	Somewhat	Not Effective	Worse	Date
Physical Therapy	☐	☐	☐	☐	☐
Medications	☐	☐	☐	☐	☐
Heat / Ice	☐	☐	☐	☐	☐
Injection	☐	☐	☐	☐	☐
Rest	☐	☐	☐	☐	☐

Diagnostic Studies: What tests have been completed? (List dates)

MRI _____ CT Scan _____ X-rays _____ EMG _____

Office Use Only: Weight: _____ Height: _____ Blood Pressure: _____

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Past Medical History: Please mark any medical problem that you have now or have had in the past.

☐ High blood pressure	☐ Diabetes	☐ Emphysema/COPD	☐ Asthma	☐ TB
☐ Stroke/TIA	☐ Heart Disease	☐ Angina	☐ Rheumatoid	☐ Fibromyalgia
☐ High Cholesterol	☐ Aneurysm	☐ Stomach Ulcer	☐ Hepatitis	☐ Acid Reflux
☐ Thyroid disease	☐ Osteoporosis	☐ Seizure disorder	☐ Kidney Disease	
☐ Currently pregnant	☐ Depression	☐ Bleeding disorder	☐ Reaction to Anesthesia	

Other psychiatric illness (type): _____

Cancer (type): _____

Other medical illness (describe): _____

Reasons you cannot have an MRI: _____

Medication Allergies: List any medication allergy you have experienced. ☐ No Allergies

Name	Reaction	Name	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

Any know Allergies to Iodine/ Betadine/ IV Dye: ☐ YES ☐ NO

Medications: List the medications and dose that you take.

Name	Dosage	How Often	Name	Dosage	How Often
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Family History: Please mark any medical problems that exist in your family.

	Diabetes	High Blood Pressure	Heart Disease	Stroke	Mental Illness	Cancer	Bleeding Disorder	Emphysema/ COPD	Other
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐	☐	☐	☐
Daughter(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Son(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐
Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐
Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Social History:

What is your current marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

What is your current occupation? _____

What is your current work status? ☐ Fulltime ☐ Part Time ☐ Limited Duty ☐ Unable to Work ☐ Without Employment

The last date I worked was: _____ I have been on disability since: _____

Do you smoke tobacco? ☐ YES ☐ NO How many packs/day? _____ For how long? _____

Do you consume alcohol? ☐ YES ☐ NO How much? _____ How often? _____

Have you ever had a problem with alcohol in the past? ☐ YES ☐ NO When? _____

Have you ever used illegal drugs? ☐ YES ☐ NO When? _____

Have you ever had an addiction problem with narcotic pain medications? ☐ YES ☐ NO When? _____

Past Surgical History: Please list any surgery you have had in the past with the approximate date.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Your Pharmacy: _____

Review of Symptoms for the Last Six Months: Check the signs/symptoms you are experiencing.

Constitutional:
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Fever
- ☐ Chills
- ☐ Sexual Dysfunction

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bowel Incontinence
- ☐ Blood in Stool

Cardiovascular/Respiratory:
- ☐ Chest Pain (angina)
- ☐ Palpitations
- ☐ Heart Arrhythmia
- ☐ Shortness of Breath

Eyes:
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Loss of Vision

Head/Ears/Nose/Throat
- ☐ Headache
- ☐ Nasal Drainage

Urinary:
- ☐ Difficulty Urinating
- ☐ Urinary Incontinence
- ☐ Urgency

Neurological:
- ☐ Seizure
- ☐ Memory Loss
- ☐ Confusion

Psychiatric:
- ☐ Depression
- ☐ Mania
- ☐ Other

Musculoskeletal:
- ☐ Leg Cramps
- ☐ Swelling
- ☐ Painful Joints
- ☐ Muscle Loss
- ☐ Bruising

Skin:
- ☐ Cancer
- ☐ Rash
- ☐ Ulcer

Allergy:
- ☐ Seasonal
- ☐ Tape
- ☐ Food
- ☐ Other

Which physician(s) is/are treating these conditions? _____

I hereby certify that the above information is correct to the best of my knowledge. I will not hold my physician(s) or any of their staff responsible for any errors or omissions I have made in completing this form.

Signature: _____ Date: _____