

# Advanced Interventional Pain Management, PA

Patient Name \_\_\_\_\_ MRN \_\_\_\_\_

Please help us to get to know you better:

Please list the Physicians that care for you:

Primary Physician \_\_\_\_\_

Referring Physician \_\_\_\_\_

Other Physician \_\_\_\_\_

Are you \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed or widower

Are you Pregnant? No Yes Planning a pregnancy? Yes No

Number of children you have? \_\_\_\_\_

Are you currently working? No Yes

\_\_\_\_\_ Fulltime \_\_\_\_\_ Part-time \_\_\_\_\_ Unemployed \_\_\_\_\_ Retired \_\_\_\_\_ Disabled

What is/was your usual occupation? \_\_\_\_\_

Do you use tobacco products? No

Yes \_\_\_\_\_ Chew/Dip \_\_\_\_\_ Smoke: How long? \_\_\_\_\_ Packs/day \_\_\_\_\_

Quit \_\_\_\_\_ Chew/Dip \_\_\_\_\_ Smoke: How long? \_\_\_\_\_ Packs/day \_\_\_\_\_

How often do you consume alcoholic beverages?

Never Less than one drink per week 1-5/week 6-10/week

11-15/week 16-20/week 21 or more/week

Do you use recreational drugs (street drugs)? No Yes Quit If yes, please list:

What diseases run in your family?

Cancer Diabetes Liver Disease Hypertension COPD Heart Disease

Alcoholism Substance Abuse Thyroid Disorders Kidney Disease Bleeding Disorders

What is the highest level of education you reached? \_\_\_\_\_

Are you able to operate a vehicle? Yes No

If No, what is your mode of transportation? \_\_\_\_\_

Do you use any device to help with your mobility?

\_\_\_\_\_ Cane \_\_\_\_\_ Wheelchair \_\_\_\_\_ Walker \_\_\_\_\_ Motorized Wheelchair

\_\_\_\_\_ All the time \_\_\_\_\_ Occasionally \_\_\_\_\_ As needed \_\_\_\_\_ Rarely

Have you ever used any of the following devices for your pain and how did it help if at all?

TENS Units	very much	somewhat	not at all	never used
RS4 Stimulator	very much	somewhat	not at all	never used
Heat application	very much	somewhat	not at all	never used
Cold application	very much	somewhat	not at all	never used
Exercise	very much	somewhat	not at all	never used
Mesh glove	very much	somewhat	not at all	never used
Back brace	very much	somewhat	not at all	never used
Splints/Collars	very much	somewhat	not at all	never used
OTC medications	very much	somewhat	not at all	never used

Please list all OTC (over-the-counter) medications you have taken for your pain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

