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:

_____

_____

_____