**ADVANCED INTERVENTIONAL PAIN CONSULTANTS Initial Consultation**

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Age** \_\_\_\_\_

**PRIMARY CARE DOCTOR** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **REFERRING PHYSICIAN** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your **MAIN PAIN COMPLAINT**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY OF PRESENT ILLNESS**

**When and how** did the pain start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Where you involved in a **motor vehicle accident**? \_\_\_ Yes\_\_\_ No\_\_\_ Did you sustain a **work related injury**? \_\_\_Yes \_\_\_ No

**Where** is your pain located? **How intense** is your pain?

Draw in the diagram where your pain is located Circle the lowest and highest levels

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How do you best **describe** your pain?

 \_\_\_ Aching \_\_\_ Electrical \_\_\_ Stabbing \_\_\_ Sharp

 \_\_\_ Dull \_\_\_Throbbing \_\_\_ Shock-like \_\_\_ Burning

 What is the **pattern** of your pain?

 \_\_\_ Constant \_\_\_ Intermittent

 \_\_\_ Mornings \_\_\_ Afternoons \_\_\_ Nights

Does the pain **radiate** to other areas? \_\_\_Yes \_\_\_No

If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any **associated symptoms?** \_\_\_ Numbness \_\_\_ Tingling \_\_\_ Weakness \_\_\_ Muscle spasms \_\_\_ Others, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes the pain **worse**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes the pain **better**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Overtime, is the pain getting? \_\_\_ Better \_\_\_ Worse \_\_\_ About the same

**HOW DOES PAIN AFFECT YOUR QUALITY OF LIFE?** Explain

\_\_\_ Family life/marriage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Ability to work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Ability to sleep \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Activities of daily living \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Sex life \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What **MEDICATIONS** have you used in the past for pain relief?

**Opioids** \_\_\_ Morphine (Avinza, Kadian, MS Contin)

 \_\_\_ Oxycodone (Oxycontin, Percocet, Percodan, Endocet)

 \_\_\_ Codeine (Tylenol #3 or #4)

 \_\_\_ Hydrocodone (Vicodin, Norco, Vicoprofen, Lortab, Lorcet, Zohydro)

 \_\_\_ Tramadol (Ultram)

 \_\_\_ Hydromorphone (Dilaudid, Exalgo)

 \_\_\_ Oxymorphone (Opana)

 \_\_\_ Fentanyl (Duragesic, Fentora, Actiq)

 \_\_\_ Tapentadol (Nucynta)

\_\_\_ Buprenorphine (Butrans, Subaxone, Subutex)

\_\_\_ Methadone (Dolophine)

**Anti-inflammatories** \_\_\_ Ibuprofen (Motrin, Advil) \_\_\_Naproxen (Naprosyn, Anaprox, Naprelan, Aleve)

\_\_\_ Meloxicam (Mobic) \_\_\_Piroxicam (Feldane) \_\_\_Celecoxib (Celebrex) \_\_\_Etodolac

\_\_\_ Diclofenac (Voltaren) \_\_\_Nabumetone (Relafen)

**Muscle relaxants** \_\_\_ Carisoprodol (Soma), \_\_\_Baclofen, \_\_\_Cyclobenzaprine (Flexeril, Amrix)

 \_\_\_Metaxalone (Skelaxin), \_\_\_Tizanidine (Zanaflex), \_\_\_Methacabamol (Robaxin)

**Anticonvulsants** \_\_\_ Gabapentin (Neurontin), \_\_\_Pregabalin (Lyrica), \_\_\_Topiramate (Topamax)

\_\_\_ Carbamazepine (Tegretol), \_\_\_Oxcarbazepine (Trileptal), \_\_\_Phenytoin (Dilatin)

\_\_\_ Lamotrigine (Lamictal)

**Antidepressants** \_\_\_ Duloxetine (Cymbalta) \_\_\_Venalafaxine (Effexor) \_\_\_Desvenlafaxine (Prestiq),

\_\_\_ Milnacipran (Savella) \_\_\_Amitriptyline (Elavil) \_\_\_Nortriptyline (Pamelor) \_\_\_Fluoxitine (Prozac)

\_\_\_ Citalopram (Celexa) \_\_\_Sertraline (Zoloft) \_\_\_Trazadone (Desyrel) \_\_\_Mitarzipine (Remeron),

\_\_\_ Bupropion (Wellbutrin)

**Benzodiazepines** \_\_\_ Alprazolam (Xanax) Lorazepam (Ativan) Diazepam (Valium) Clonazepam (Klonopin)

**Sleep aids** \_\_\_ Zolpidem (Ambien) Eszopiclone (Lunesta) \_\_\_ Zaleplon (Sonata) \_\_\_ Ramelteon (Rozeram)

Have you been treated by a **pain management doctor**(s) before? \_\_\_ No \_\_\_ Yes

List the doctor(s) name(s) and dates? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Have you had **pain injections** in the past? \_\_\_ No \_\_\_ Yes

 If yes, what type of injections and date of the injections? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a **spinal cord stimulator trial** and/ora **permanent implant placed**? \_\_\_ No \_\_\_ Yes

 If yes, date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who performed the placement?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a **pain pump** implanted? \_\_\_ No \_\_\_ Yes

 If yes, date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who performed the placement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER TREATMENT MODALITIES** **Date Helped No change**

\_\_\_ Exercise \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

 \_\_\_ Acupuncture \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

 \_\_\_ Massage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

 \_\_\_ Hot packs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

\_\_\_ Cold packs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

 \_\_\_ TENS units \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

 \_\_\_ Yoga \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

 \_\_\_ Holistic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

 \_\_\_ Spiritual \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

\_\_\_ Physical therapy

 Standard \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

 Aquatic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

 \_\_\_ Chiropractor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

\_\_\_ Psychological

 Counseling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

 Biofeedback \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

 Cognitive \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_

**PAST SURGICAL HISTORY** List all past surgeries and dates

1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY**

 \_\_\_ Heart disease \_\_\_ Congestive heart failure \_\_\_ Coronary artery disease \_\_\_ Heart attacks

 \_\_\_ Bypass surgery \_\_\_ Coronary stents

\_\_\_ Hypertension \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Stroke \_\_\_Transient ischemic attack\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_Thyroid disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ COPD \_\_\_ Asthma \_\_\_ Emphysema \_\_\_ **Obstructive Sleep Apnea**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Liver disease \_\_\_ Cirrhosis \_\_\_ Hepatitis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Seizures \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Fibromyalgia \_\_\_ Rheumatoid arthritis \_\_\_ Ankylosing Spondylitis \_\_\_ Lupus \_\_\_Psoriatic arthritis

 \_\_\_ Osteoarthritis \_\_\_ Osteoporosis \_\_\_ Fibromyalgia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Multiple sclerosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Headaches \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Depression \_\_\_ Anxiety \_\_\_ Bipolar disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ HIV Positive \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you **ALLERGIC** or sensitive to any medications? \_\_\_ No \_\_\_ Yes List \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

List all **MEDICATIONS FOR PAIN** are you currently taking. Include dose, times per day taken, and name of prescribing doctor

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all **OTHER MEDICATIONS** you are currently taking. Include dose and times per day taken

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any **blood thinners**? \_\_\_ Plavix \_\_\_ Coumadin \_\_\_ Lovenox \_\_\_ Heparin \_\_\_ Aspirin \_\_\_ Digabatran (Vigabatin)

 \_\_\_ Apixoban (Elquis) \_\_\_ Rivaroxaban (Xarelto) \_\_\_ Edoxaban (Lixiana) \_\_\_ Alteplase (Aclilyse) \_\_\_ Ticlopidine (Ticlid)

**SOCIAL HISTORY**

Are you employed? \_\_\_ No \_\_\_Yes, what is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you disabled? \_\_\_No \_\_\_Yes

Marital status: \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Separated How many children do you have? \_\_\_\_

Do you drink? \_\_\_ No \_\_\_ Yes How many drinks per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? \_\_\_ No \_\_\_ Yes How many cigarettes or packs per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently use or have you ever used illicit drugs? \_\_\_ No \_\_\_ Yes, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever abused narcotics or prescription medications? \_\_\_ No \_\_\_ Yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under the care of a Psychiatrist or Psychologist? \_\_\_ No \_\_\_ Yes

If yes, what is the name of your Psychiatrist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Psychologist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any significant traumatic events in your life \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FAMILY HISTORY**

Does anyone in your family have a history of back or neck pain, depression, anxiety, or substance abuse (alcohol or drugs)?

\_\_\_ No \_\_\_ Yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**REVIEW OF SYSTEMS Circle all that apply** \_\_\_\_ No problems

**1. General**  Weight gain or loss, unexplained hair loss, fever or chills, low energy, too sleepy, too tired

**2. ENT**  Eye pain, vision problems (blurred vision, loss of vision), hearing loss, swollen glands in neck, sore throat/pain when swallowing, dental problems

**3. Cardiovascular**  Chest pain (sharp, crushing, or heaviness), heart racing (palpitations), fainting spells, shortness of breath, swelling of legs (edema)

**4. Respiratory** Shortness of breath, cough/coughing up blood

**5. Gastrointestinal**  Increased appetite,decreased appetite, stomach pain, nausea/vomiting, diarrhea, constipation

**6. Genitourinary**   Pain when passing water (urination), blood in urine, urinating more than usual (day and/or night), bladder Infection,pain during sex, changes in sex drive (libido)

**7. Musculoskeletal** Limited motion of arms or leg, joint pain, swelling/redness, numbness, tingling, or weakness in arms or legs

**8. Neurological**  Arm/leg weakness,new headaches, problems with memory or speech, tremors

**9. Psychiatric**  Sadness, stress, anxious, seeing or hearing things, suicidal thoughts, feeling down, insomnia

**10. Endocrine**  Weight gain/loss,thirsty all the time, cannot stand temperature changes (heat/cold)

**11. Lymph**  Swollen glands (armpits or groin)

**12. Skin** Rash (palm of hands, sole of feet), changes in skin, sores or rash on skin

**13. Allergies**  Hives/skin rashes, allergic reaction to foods

**SLEEP APNEA SURVEY** \_\_\_ Excessive loud snoring \_\_\_ Gasping or choking for breath while sleeping \_\_\_ Tired after sleeping

 \_\_\_ Falling asleep and daytime tiredness \_\_\_ Witnessed respiratory pauses \_\_\_ Night time difficulties

 \_\_\_ Have high blood pressure

I attest that ALL information I have provided is accurate and factual, and I can provide supporting information.

**Patient‘s Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_