GRANITE STATE PAIN ASSOCIATES

GRANITE STATE SURGICENTER

www.PainMD.com

# Health History Form

Name: _____ Date of Birth: _____ (MM/DD/YYYY)

Reason for today's visit: _____

Please mark the types of healthcare providers you have previously seen for this condition:

❑ Primary Care Provider ❑ Orthopedic Surgeon ❑ Rheumatologist (Arthritis)

❑ Neurologist ❑ Neurosurgeon ❑ Physiatrist ❑ Physical/Occupational Therapy

❑ Chiropractor ❑ Acupuncture ❑ Other Pain Management Specialist

In the space below please name the providers marked above and the approximate dates you were treated:

_____

Please mark any exams you have previously had for this condition:

❑ X-Ray ❑ Ultrasound ❑ CT-Scan ❑ MRI ❑ PET Scan ❑ Body Scan

❑ EMG ❑ Sleep Study ❑ EKG ❑ Pulmonary Function Studies

In the space below please indicate which area of the body correlated with the exam and approximate date of exam:

_____

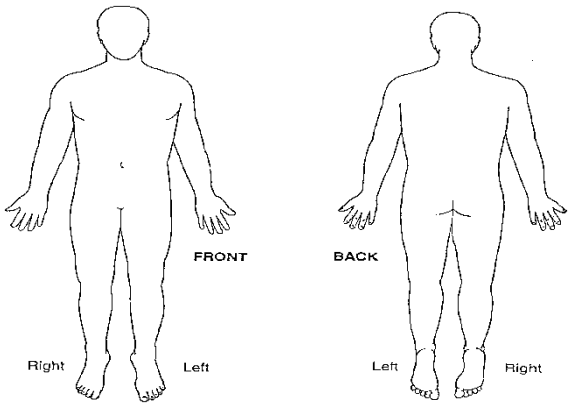
Please list other treatments/procedures you have used to treat this condition:

_____

## *PAIN TREATMENT HISTORY*

| **PAIN:** | Location 1 | Location 2 | Location 3 |
|---|---|---|---|
| Where is your pain? | | | |
| When did it start? | | | |
| How did it begin? (*Suddenly, gradually, injury, at work, fall, etc.*) | | | |
| What does it feel like: *(Burning, aching, sharp, dull, shooting, etc.)* | | | |

Please draw on the diagram where your pain is located.




| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Pain level now**? (0=no pain, 10= worst imaginable pain) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Average** pain level over the last month | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Lowest** that it has been in the last month or two | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Highest** that it has been in the last month or two | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

## *PREVIOUSLY TRIALED AND FAILED MEDICATION PROFILE*

Please mark if you have taken any of the following medications for any of these conditions. In the space provided please include to the best of your memory the start and stop dales and reasons for stopping. This information is helpful in the event we need to work with your insurance company to request prior authorization for your prescribed medications. (If you choose not to complete this, it can delay completing or getting any prior authorization for your medication.)

### NSAIDs:

❑ Ibuprofen/Advil/Motrin _____ ❑ celecoxib/Celebrex _____

❑ meloxicam/Mobic _____ ❑ diclofenac/Voltaren _____

❑ naproxen/Aleve/Naprosyn _____ ❑ Pennsaid (diclofenac topical) _____

❑ nabumetone/Relafen _____ ❑ Flector (diclofenac patch) _____

❑ prednisone _____ ❑ Voltaren (diclofenac)Gel _____

❑ _____ ❑ _____

*Reasons for Discontinuing:*

_____

_____

### Short Acting:

❑ ultram/Tramadol _____ ❑ Vicodin/hydrocodone w acetaminophen _____

❑ morphine _____ ❑ Percocet/oxycodone w acetaminophen _____

❑ oxycodone _____ ❑ demerol/Meperidine _____

❑ hydromorphone/Dilaudid _____ ❑ buprenorphine/Subutex _____

❑ _____ ❑ _____

*Reasons for Discontinuing:*

_____

_____

### Long Acting:

❑ fentanyl/Duragesic patch _____ ❑ methadone/Dolophine _____

❑ morphine/Kadian _____ ❑ hydromorphone/Exalgo _____

❑ morphine/Oramorph _____ ❑ buprenorphine/Butrans _____

❑ nabumetone/Relafen _____ ❑ codeine/Oxycontin _____

❑ tramadol/Nucynta ER _____ ❑ oxymorphone/Opana _____

❑ _____ ❑ _____

*Reasons for Discontinuing:*

_____

_____

**Muscle Relaxers:**

❑ cyclobenzaprine/Flexeril _____ ❑ carisoprodol/Soma _____

❑ metazalone/Skelaxin _____ ❑ tizanidine/Zanaflex _____

❑ methocarbamol/Robaxin _____ ❑ baclofen/Lioresal _____

❑ _____ ❑ _____

*Reasons for Discontinuing:*

_____

_____

**Depression/Pain/Sleep:**

❑ citalopram/Celexa _____ ❑ escitalopram/Lexapro _____

❑ fluvoxamine/Luvox _____ ❑ paroxetine/Paxil _____

❑ buproprion/Wellbutrin _____ ❑ venlafaxine/Effexor _____

❑ zolpidem/Ambien _____ ❑ triazolam/Halcion _____

❑ estazolam/Prosom _____ ❑ eszopiclone/Lunesta _____

❑ fluoxetine/Prozac _____ ❑ sertraline/Zoloft _____

❑ temazepam/Restoril _____ ❑ trazodone/Desyrel _____

❑ ramelteon/Rozerem _____ ❑ _____

*Reasons for Discontinuing:*

_____

_____

**Central Nervous System/Neuropathic Pain/Migraine:**

❑ pramipexole/Mirapex _____ ❑ ropinorole/Requip _____

❑ gabapentin/Neurontin _____ ❑ gabapentin/Gralise _____

❑ amitriptyline/Elavil _____ ❑ topiramate/Topamax _____

❑ valproic acid/divalproex/Depakote _____ ❑ levetiracetam/Keppra _____

❑ rizatriptan/ Maxalt _____ ❑ sumatriptan/Imitrex _____

❑ zolmitriptan/Zomig _____ ❑ sumatriptan/Sumavel _____

❑ memantine/Namenda _____ ❑ carbamazepine/Tegretol _____

❑ lomatrigine/Lamictal _____ ❑ prebagalin/Lyrica _____

❑ eletriptan/Relpax _____ ❑ Treximet (sumatriptan/naproxen _____

❑ _____ ❑ _____

*Reasons for Discontinuing:*

_____

_____

*(Please circle <u>all</u> that apply):*

| | |
|---|---|
| **What aggravates your pain?** | heat \| cold \| activity \| driving \| lying down \| sitting \| standing \| walking bending \| lifting \| weather \| prolonged positions \| stress |
| **What relieves your pain?** | heat \| cold \| activity \| rest \| lying down \| sitting \| standing \| walking massage \| changing positions \| stretching \| medication |
| **Associated signs & symptoms:** | problems sleeping \| depression \| anxiety \| sexual issues decreased range of motion \| difficulty urinating \| saddle anesthesia \| bowel or bladder dysfunction \| numbness or tingling |
| **Pain is worse in:** | morning \| afternoon \| evening \| night |
| **Pain is:** | continuous \| intermittent |

***SOCIAL HISTORY*** *(Please circle all applicable responses):*

| | | |
|---|---|---|
| Marital Status | Single Significant Other Married Divorced Widowed | |
| Living Situation | Alone Spouse/Significant other Children/Family Other | |
| Females- Are you pregnant? | Yes / No Hysterectomy Menopause Tubal ligation | |
| Do you have children? | Yes / No | If yes, how many? |
| Education (highest level) | 9 10 11 12 Some college Associates Bachelors GED Masters PhD | |
| Are you working? | Yes / No | If yes, occupation? |
| Are you disabled? | Yes / No | If yes, reason? |
| Any legal actions related to a pain condition? | Yes / No | Explain: |

| | | | **If applicable, amount?** |
|---|---|---|---|
| Tobacco Use?<br>*If no, have you ever?* | Yes / No<br>Yes / No | Cigarettes / Cigars / Chew<br>Cigarettes / Cigars / Chew | Per day:<br>Per day: |
| Do you drink alcohol? | Yes / No | Beer / Wine / Liquor | Per day: |
| Do you drink caffeine? | Yes / No | Coffee / Tea / Soda / Energy Drink | Per day: |
| Any present illicit drug use? | Yes / No | Marijuana / Cocaine / Heroin / Illicit Rx. / Other | |
| Any past illicit drug use? | Yes / No | Marijuana / Cocaine / Heroin / Illicit Rx. / Other | |
| Do you exercise? | Yes / No | Type? | Per week: |
| Do you wear your seatbelt? | Yes / No | If yes, percent of time: | |
| Do you have Advanced Directives in place? | Yes / No | Living Will Durable Power of Attorney Health Care Proxy Advanced Directives | |

***SURGICAL HISTORY*** *(Please list all past surgeries/operations):*

| Type of Operation | Date | Type of Operation | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***FAMILY HISTORY*** *(Please tell us about the health of your immediate family):*

| | Father | Mother | Siblings | Children | Other |
|---|---|---|---|---|---|
| **Age at Death** | | | | | |
| **Cause of Death** | | | | | |
| **Heart Disease/ Stroke** | | | | | |
| **High Blood Pressure** | | | | | |
| **Diabetes** | | | | | |
| **Chronic Pain** | | | | | |
| **Cancer (type)** | | | | | |
| **Other:** | | | | | |

***MEDICAL HISTORY*** *(Please check any of the following that you have or have had in the past):*

- ❑ Acid Reflux/GERD
- ❑ ADHD
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Bowel Problems
- ❑ Cancer
- ❑ Chronic Cough
- ❑ Chronic Pain
- ❑ COPD/Emphysema
- ❑ Dementia
- ❑ Depression
- ❑ Diabetes
- ❑ Eating Disorder
- ❑ Glaucoma/Cataracts
- ❑ Headaches
- ❑ Hearing Loss
- ❑ Heart Disease
- ❑ Heart Palpitations
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ HIV/AIDS
- ❑ Immune Disorders
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Osteoporosis
- ❑ Seizure Disorder
- ❑ Sexually Transmitted Disease
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Other: _____

***MEDICAL AND MENTAL HEALTH HISTORY*** *(Include <u>all</u> injuries or hospitalizations):*

| Name of Facility | Reason | Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

***CURRENT MEDICATIONS***

| Name of Medication | **Strength** (ex. 500 mg) | **Dosing Instructions** (ex. Twice a day) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

***ALLERGY HISTORY***

❑ No Known Allergies ❑ Medication Allergies ❑ Environmental/Seasonal Allergies ❑ Latex Allergies

| **Allergen** (ex. Food, Dust, Animals, Pollen, Medication) | **Reaction** (ex. Rash, nausea, respiratory, shock, etc.) |
|---|---|
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| | |