GLOBAL
PAIN MANAGEMENT

Date:_____

HEALTH HISTORY QUESTIONNAIRE

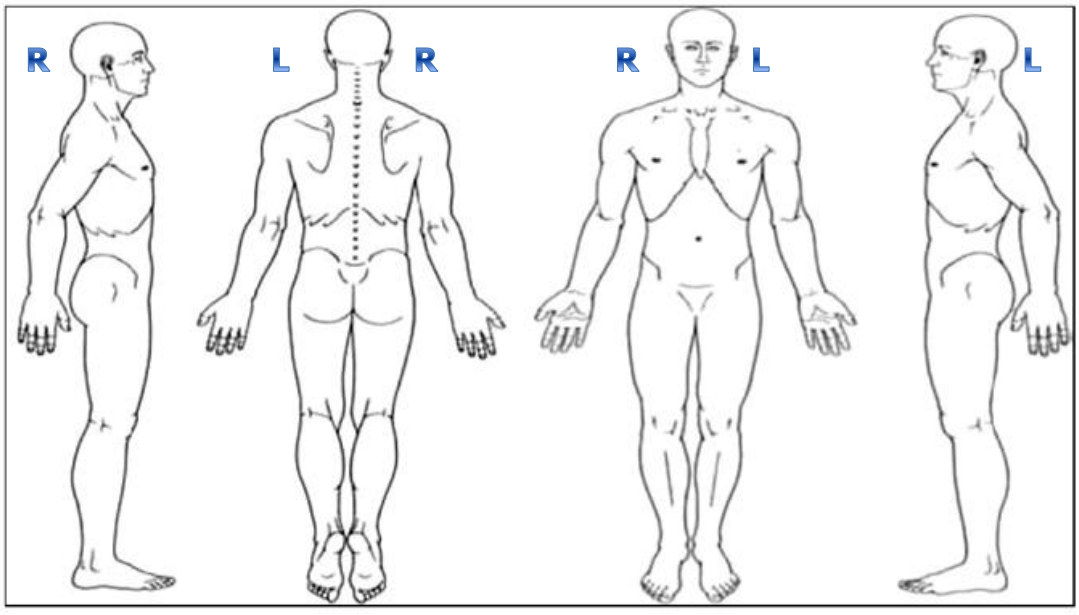
All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**	**SSN:**
Address:			
Emergency Contact: *Name:*	*Phone:*		
Referring Physician: *Name:*	*Phone:*		
Address:			
Primary Care Physician: *Name:*	*Phone:*		
Address:			

PERSONAL HEALTH HISTORY

Where is your pain located?

Please use the diagram below to indicate where most of your pain is located



When did your pain begin? *(Month, Year)*		
Is your pain related to a specific injury? *(Car accident, job-related, fall, etc..)*	☐ Yes	☐ No
Date of Injury:		
Briefly explain:		

Please circle the AVERAGE daily level of your pain												
(No Pain)	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**(Worst Pain Imaginable)**

Please circle the level of pain that is acceptable to you												
(No Pain)	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**(Worst Pain Imaginable)**

Please check the words that best describe your pain					
☐ Dull	☐ Aching	☐ Throbbing	☐ Sharp	☐ Shooting	☐ Stabbing
☐ Electric	☐ Numbness	☐ Tingling	☐ Weakness	☐ Spasm / Tightness	☐ Burning

Please let us know how the following treatments influence your pain. Please check all that apply					
Treatment	**Relieves**	**Worsens**	**No Difference**	**Eliminates**	**Never Tried**
Exercise					
Walking					
Massage					
Heat					
Cold					
TENS Therapy					
Medications					
Injections					
Acupuncture					
Biofeedback					

List your current prescribed drugs and over-the-counter drugs		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

Have you ever been treated by another pain management specialist? If so, what is the name of the doctor or practice?

Please indicate which of the following medications you have tried in the past to treat your pain
☐ Amitriptyline ☐ Butrans ☐ Fentanyl ☐ Gabapentin ☐ Hydrocodone ☐ Ibuprofen ☐ Lyrica ☐ Meloxicam ☐ Methadone ☐Morphine ☐ Naproxen ☐ Notriptyline ☐ Opana ☐ Oxycontin ☐ Percocet ☐ Tramadol

Please check the medical conditions that you have or have had in the past								
☐ High Blood Pressure	☐ Heart Disease	☐ High Cholesterol	☐ Kidney Stones	☐ Kidney Failure	☐ COPD	☐ Cancer	☐ OCD	
☐ Anxiety	☐ ADHD	☐ Schizophrenia	☐ Depression	☐ Bipolar Disorder	☐ GERD	☐ Thyroid Disease	☐ Asthma	☐Cirrhosis
☐ Seizures		☐ Diabetes		☐Other_____		☐Other_____		

Please list all surgeries that you have had		
Date	**Surgeon / Facility**	**Surgical Procedure**

SOCIAL HISTORY

Are you currently employed? If so, what is your occupation?					☐ Yes	☐ No
Are you presently being treated as a result of a claim made to Worker's Compensation?					☐ Yes	☐ No
Are you currently applying for, or receiving, disability benefits?					☐ Yes	☐ No
Are you involved in any legal action relating to your pain?					☐ Yes	☐ No
Please indicate your marital status	☐ Single	☐ Married	☐ Widowed	☐ Divorced	☐ Separated	☐ Widowed
Do you smoke cigarettes?		☐ Yes	☐ No	____Packs per day since age____		
Do you consume alcohol? If so, how often and how much do you drink?					☐ Yes	☐ No
Do you currently use, or have you used, recreational drugs? If so, which drug(s) and when?					☐ Yes	☐ No
Have you ever abused drugs? If so, which drug(s) and when?					☐ Yes	☐ No
Have you ever abused prescription drugs? If so, which drug(s) and when?					☐ Yes	☐ No
Has anyone in your family ever abused alcohol, illegal drugs, or prescription drugs?					☐ Yes	☐ No

FAMILY HISTORY

Please list any family medical history

REVIEW OF SYSTEMS

Please circle any problems, illnesses, or injuries that you have had	
Constitutional	☐ Fever ☐ Chills ☐ Night Sweats ☐ Weight Gain ☐ Weight Loss ☐ Fatigue ☐ Body Aches ☐ Decreased Appetite
Eyes	☐ Pain ☐ Redness ☐ Vision Changes ☐ Itching ☐ Discharge
ENT	☐ Ear Pain ☐ Hearing Loss ☐ Nasal Congestion ☐ Sore Throat ☐ Ringing in Ears
Respiratory	☐ Shortness of Breath ☐ Cough ☐ Wheezing ☐ Sputum Production
Cardiovascular	☐ Chest Pain ☐ Palpitations ☐ Leg Swelling
GI	☐ Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ Bloody Stool ☐ Nausea ☐ Vomiting ☐ Reflux
Neurological	☐ Headache ☐Weakness ☐ Numbness ☐ Dizziness ☐ Difficulty Speaking ☐ Seizures
Musculoskeletal	☐ Neck Pain ☐ Lower Back Pain ☐ Thoracic Pain ☐ Joint Pain ☐ Joint Swelling
Skin	☐ Rash ☐ Itching
Endocrine	☐ Frequent Urination ☐ Increased Thirst ☐ Heat Intolerance ☐ Cold Intolerance
Psychiatric	☐ Anxiety ☐ Depression ☐ Insomnia

_____ _____

Signature Date