History Form - New Patient

HISTORY - COMPLETED BY PATIENT

Name: Date:

1. Reason for your visit today_____Primary Care MD/provider:_____

2. Please indicate if you are having any current problems or symptoms in any of the following areas:

- ❒ General(fever, fatigue,wt change, etc)
- ❒ Eyes, ears, nose or throat
- ❒ Skin rash, skin lesions
- ❒ Dizziness, fainting, irreg heart beat
- ❒ Cough, chest pain, shortness of breath etc
- ❒ Nausea, abdom. pain, diarrhea etc
- ❒ Liver or kidney problem
- ❒ Muscles/Joints: pain, swelling
- ❒ Back or leg pain
- ❒ Nerve: numbness, paralysis
- ❒ Bladder/Urinary problem
- ❒ Diabetes, thyroid disorder
- ❒ Depression, anxiety, bipolar
- ❒ Sleep apnea, sleep disorder
- ❒ Abnormal blood tests
- ❒ Other

Comments:

❒ reviewed per MD

3. Medication(s) OR: if have list, check ❒ and attach

4. Previous (major) surgeries and approx date:

5. Allergic or severe reaction to any medication (Penicillin, Sulfa, etc)?

6. Social History

If working outside the home, please tell me briefly, what you do: _____

Are you married? ❒yes ❒no Do you live alone: ❒yes ❒no

Do you exercise, for its own sake? _____times/week What is your favorite hobby/recreational activity?_____

Have you ever been treated for alcohol or substance abuse? ❒yes ❒no Do you see a personal counselor or therapist?_____AA/NA?_____

Do you smoke cigarettes? ❒yes ❒no If you now smoke, or have smoked cigarettes, for how many years?_____

My *average* alcohol intake is: (glasses/drinks) _____ per day _____ per week _____per month

Do you use marijuana regularly? ❒yes ❒no Do you have a medical MJ authorization? ❒yes ❒no

StatCare

Name:_____ Date:_____

Medical History *have you ever had any of the following:*	Family History
__*Arthritis* __Osteoarthritis __Rheumatoid __Allergies (Seasonal, Etc.) __Asthma __Bleeding problems __Blood clots/Deep Vein Thrombosis __Blood transfusion __COPD/emphysema __Fracture: _____ __Fibromyalgia __*Headache* __Migraine __ Tension __*Cancer:* Site/type_____ *Heart disease:* __Coronary Heart Disease __Angioplasty or bypass (yr)____ __Congestive Heart Failure __Heart valve problems __High Blood Pressure __tachycardia or atrial fibrillation __Ulcers __GERD/hiatal hernia/reflux __Hepatitis B or C __Colitis, Polyps, Irritable Bowel __Kidney/Bladder problem:_____ __Loss of control of bladder or bowel __Back problems, sciatica or rupt. disc __Depression __Bipolar disorder __Anxiety or Panic Attacks Other:_____ __Seizures/Epilepsy __Stroke __Sleep Apnea (not insomnia) __Thyroid (high/low) __Tuberculosis (positive TB test) Other:_____ _____ __Anemia __Diabetes __Eating disorder __High Cholesterol/Triglycerides __Gout __Osteoporosis __*Gluten Sensitivity/SPRUE*	*Anyone in your IMMEDIATE family have:* ***Use this format:*** ***F= father*** ***M = mother*** ***S= sibling (brother/sister*** _____Cancer (type)_____ _____High Blood Pressure _____Coronary Heart Disease _____Heart Attack – age ____ _____Stroke _____Other vascular disease _____Diabetes _____Fibromyalgia _____Alcohol/Substance Abuse _____Bipolar _____Colonic Polyps _____Thyroid disease Other:_____ _____ **Date When was your last:** _____ Physical with blood work _____ Pap Smear _____ Mammogram _____ Prostate/digital rectal exam/PSA _____ Colorectal cancer screening (Colonoscopy)

Consultation: Chronic Pain

Name: _____Date: _____

The physician who most recently helped manage my pain condition:

Name: _____

Treatments in current use or tried in the past (**circle** if treatment helpful, **cross out** if **not** helpful):

Physical therapy, Massage or chiropractic, acupuncture

Antidepressants, flexeril(cyclobenzaprine), tizanidine, soma, baclofen, robaxin (methocarbamol), anti-inflammatories(ibuprofen, naproxen, celebrex)

Injections: Spinal, trigger point

Neurontin (gabapentin), Lyrica, nortriptyline, amitriptyline, Effexor (venlafaxine), Cymbalta,

Savella, Topamax, Depakote

Methadone, Morphine, Oxycodone, Oxycontin, Fentanyl, Dilaudid, Hydrocodone, Tramadol (Ultram), Nucynta, Exalgo, Opana, Cannabis

I have seen a specialist in:

Orthopedic surgery:
Pain management:
Neurology or Rheumatology:
Neurosurgery:

Have you ever had a DUI, been treated for drug or alcohol addiction?
(A history of chemical addiction is not necessarily a contraindication against pain medication treatment, but must be taken into account in the treatment plan.) YES NO

Signature: _____

DRUG USE QUESTIONNAIRE (DAST-20)

Name: _____ Date: _____

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question.

In the statements "drug use" refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

For information on the DAST, contact Dr. Harvey Skinner at the Addiction Research Foundation, 33 Russell St., Toronto, Canada, M5S 2S1.

These questions refer to the past 12 months.

Circle your response

1. Have you used drugs other than those required for medical reasons?..... Yes No
2. Have you abused prescription drugs? ..... Yes No
3. Do you abuse more than one drug at a time? ..... Yes No
4. Can you get through the week without using drugs? ..... Yes No
5. Are you always able to stop using drugs when you want to?..... Yes No
6. Have you had "blackouts" or "flashbacks" as a result of drug use? ..... Yes No
7. Do you ever feel bad or guilty about your drug use? ..... Yes No
8. Does your spouse (or parents) ever complain about your involvement with drugs? ..... Yes No
9. Has drug abuse created problems between you and your spouse or your parents? ..... Yes No
10. Have you lost friends because of your use of drugs? ..... Yes No
11. Have you neglected your family because of your use of drugs? ..... Yes No
12. Have you been in trouble at work because of drug abuse? ..... Yes No
13. Have you lost a job because of drug abuse? ..... Yes No
14. Have you gotten into fights when under the influence of drugs? ..... Yes No
15. Have you engaged in illegal activities in order to obtain drugs? ..... Yes No
16. Have you been arrested for possession of illegal drugs? ..... Yes No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? ..... Yes No
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?..... Yes No
19. Have you gone to anyone for help for a drug problem? ..... Yes No
20. Have you been involved in a treatment program specifically related to drug use? ..... Yes No

NAME:_____

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NAME_____ DATE:_____

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

NAME_____