HISTORY FORM

PREMIER
PAIN MANAGEMENT

33 Electric Ave, Suite 102, Fitchburg, MA 01420
Phone: (978) 343-PAIN Fax: (978) 343-7247
www.premierpainfitchburg.com

Please complete ALL QUESTIONS to help us better understand your problem

Date: _____

Name: _____ **Age:** _____ **Date of Birth:** _____

Height: _____**Weight**:_____

Who referred you to us? _____

Family/Primary Care Physician: _____
Phone:_____

PAIN HISTORY

What part of your body hurts THE MOST? _____

How long have you had this pain? _____

How did this pain begin? _____

Have you ever been evaluated or treated for this pain? _____

Please list any physicians you have seen for your pain:

Name	Specialty	Recommendations
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Was pain caused from: □ MVA/Trauma □ Illness □ Unknown Cause

If MVA/Trauma please explain and give dates:

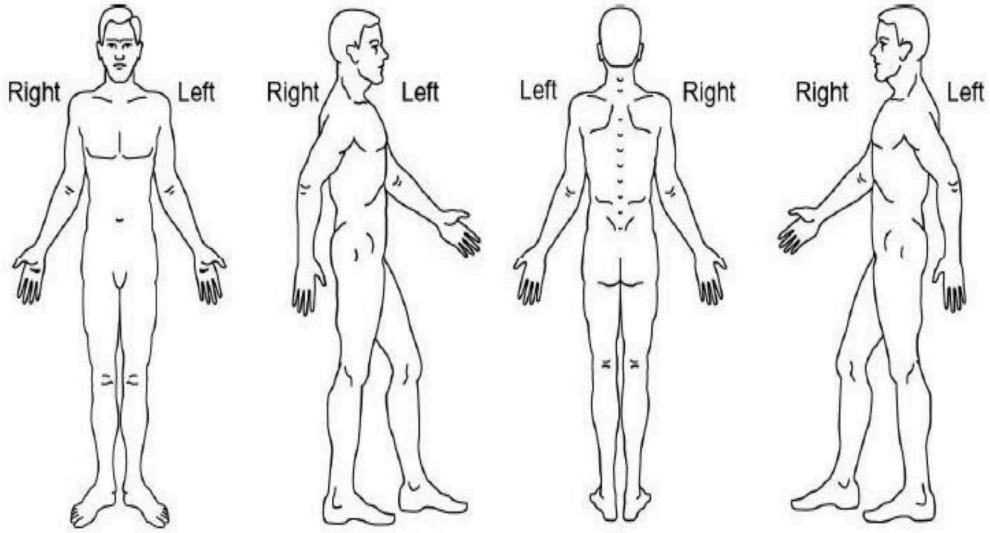
_____

Are you involved in any litigation or lawsuit as a result of your pain? □Yes □No

Are you seeking Workers Compensation as a result of your pain? □Yes □No

Is the pain <u>constantly</u> or <u>intermittently</u> present? _____

Using the diagram below, please circle the areas of your pain



Please check the boxes that best describe your pain

□Achy □Dull □ Throbbing □ Cramping □Tightness □Sharp □Stabbing
□Shooting □Burning □Numbness □Tingling □ Other _____

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Please indicate the factors that increase or decrease your pain:

FACTOR	Increase	Decrease	No effect	FACTOR	Increase	Decrease	No effect
Bending backwards				Prolonged Standing			
Bending forward				Prolonged Sitting			
Weather				Heat			
Cough/Sneeze				Cold			
Going up/down stairs				Lifting objects			
Physical Activity				Bowel Movement			
Lying down				Distraction			
Walking				Driving			
Looking up/down				Standing up from seated			

Please explain any other factors that increase or decrease your pain:

_____

Have you had any of the following symptoms associated with your pain?

□ Numbness □Tingling □Bowel/bladder incontinence □Numbness in inner part of thighs or rectal area □Loss of strength in arms or legs

If yes, were these symptoms present before the pain began? □Yes □No

Does the pain radiate to any other locations (i.e. down your legs)? □Yes □No

If yes, please explain: _____

On a scale of 0 to 10, "0" being no pain and "10" being the worst pain imaginable, circle the number that describes your pain:

No pain = 0 1 2 3 4 5 6 7 8 9 10 = Worst pain imaginable

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Have you been on any medications to manage your pain? □Yes □No

If yes, please list all medications and dosages used to treat your pain

Medication and Dose	Times taken daily	Currently taking?	Did it help?
			□Yes □No
			□Yes □No
			□Yes □No
			□Yes □No

Please provide details about any interventions you have had for your pain issues:

Intervention	Details	Did it help?
Injections/Nerve blocks		□Yes □No
Physical Therapy		□Yes □No
Surgery		□Yes □No
Acupuncture		□Yes □No
Chiropractor		□Yes □No
Psychologist/Psychiatrist		□Yes □No

Which diagnostic tests have you had for your pain issues?

Test	Body Part	Date	Location
MRI			
CT Scan			
X-Ray			
EMG			
Myelogram			
Discogram			
Bone Scan			

□ **I have not had any diagnostic tests performed for my current pain complaints**

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PAST MEDICAL HISTORY

Please list all chronic medical conditions:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PAST SURGICAL HISTORY

Please list all prior surgical procedures and dates:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

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MEDICATIONS

Please list all medications and dosages that you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Do you take any blood thinners (i.e. Coumadin, warfarin, aspirin, Eliquis, Pradaxa, heparin, Pletal, Plavix)? □Yes □No

If yes, please explain: _____

Name and phone number of prescribing physician: _____

ALLERGIES

Please list all medications that you are allergic to and the reaction that occurs:

MEDICATION	REACTION
1.	
2.	
3.	
4.	

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FAMILY HISTORY

Does anyone in your immediate family (parents, siblings) have any serious chronic medical issues? □Yes □No

Relationship	Illness
Father	
Mother	
Brother(s)	
Sister(s)	
Grandparents	

SOCIAL HISTORY

Do you smoke cigarettes? □Yes □No

If yes,

1. **How many packs per day to you smoke?** _____
2. **How long have you been smoking?** _____

Do you drink any alcohol? □Yes □No

If yes,

1. **Have you ever felt the need to cut down on your drinking or drug use?** □Yes □No
2. **Have people annoyed you by criticizing your drinking or your drug use?** □Yes □No
3. **Have you ever felt bad or guilty about your drinking or your drug use?** □Yes □No
4. **Have you ever needed an "eye opener" the first thing in the morning?** □Yes □No

Have you ever or do you currently use any of the following?

□Cocaine/Crack □Marijuana □Ecstasy □MDMA □Methamphetamine □Heroin
□Any other illegal drugs? _____

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Do you currently work? □Yes □No

If yes, what is your occupation? _____

Marital Status
□Single □Married □Divorced □Separated □Widowed

Number of Children: _____

REVIEW OF SYSTEMS

Please indicate below if you currently have any of the following symptoms:

Constitutional

□Fever □Chills □Malaise □Unexpected weight change □Lack of energy
□Loss of appetite □Night sweats

Eyes

□Eye pain □Eye redness □Eye tearing □Loss of vision □Blurred Vision □Double vision □Dryness

Ears

□Ear ache □Ringing in ears □Loss of hearing

Nose/Throat/Mouth

□Loss of smell □Nosebleeds □Congestion/Runny Nose □Bleeding gums □Sore throat □Hoarseness □Difficulty swallowing □Mouth Sores

Cardiovascular

□Chest pain □Palpitations □Cramping in legs with walking □Swelling in arms or legs
□Heart murmurs

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Respiratory

□Cough □Shortness of breath with exertion □Shortness of breath when lying down
□Wheezing □Asthma □COPD □ Chest pain with breathing

Gastrointestinal

□Nausea □Vomiting □Abdominal pain □Diarrhea □Constipation □Heartburn
□Indigestion □Gas/Bloating □Yellow skin □Bowel incontinence

Genitourinary

□Urinary incontinence □Painful urination □Blood in urine □Increased frequency
□Difficulty starting urination □Increased urgency □Decreased libido

Neurologic

□Numbness □Tingling □Weakness □Memory Loss □Dizziness □Frequent headaches

Musculoskeletal

□Back pain □Neck pain □Joint pain □Joint swelling □History of joint replacement
□Stiffness □Sciatica □Muscle cramps

Hematologic/Lymphatic

□Easy bleeding/bruising □Anemia □Easy clotting

Allergic/Immunologic

□Seasonal allergies □Latex allergy □Food allergy □Medication allergy

Skin

□Rash □Itching □Dry skin □Changes in skin □Changes in hair □Hair loss □Color changes of hands/feet with cold □Changes in nail □Skin redness

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Endocrine

□Sensitive to heat □Sensitive to cold □Increased thirst □Increased hunger □Excessive sweating

Psychiatric

□Depression □Anxiety □Hearing voices □Thoughts of suicide □Thoughts of homicide □Difficulty concentrating

OPIOID RISK TOOL (ORT)

Please mark each box that applies

Mark each box that applies	**Female**	**Male**
Family history of substance abuse 1. Alcohol 2. Illegal Drugs 3. Prescription Drugs	 **□1** **□2** **□4**	 **□3** **□3** **□4**
Personal history of substance abuse 1. Alcohol 2. Illegal Drugs 3. Prescription Drugs	 **□3** **□4** **□5**	 **□3** **□4** **□5**
Age (mark box if 16-45 yo)	**□1**	**□1**
History of preadolescent sexual abuse	**□3**	**□0**
Psychologic Disease *1. ADD, OCD, Bipolar Disorder, Schizophrenia* *2. Depression*	 **□2** **□1**	 **□2** **□1**
Score Total		

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COMM Please complete if on chronic opioid therapy at this time. *Keep in mind, we are only asking about the past 30 days.*

Please answer the questions using the following scale	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
	0	**1**	**2**	**3**	**4**
1. How often have you had problems with thinking clearly or memory problems?	☐	☐	☐	☐	☐
2. How often do people complain that you are not completing necessary tasks?	☐	☐	☐	☐	☐
3. How often have you had to go to someone other than your prescribing physician to get sufficient relief from pain medications?	☐	☐	☐	☐	☐
4. How often have you taken your medications different than the way they are prescribed?	☐	☐	☐	☐	☐
5. How often have you seriously thought about hurting yourself?	☐	☐	☐	☐	☐
6. How often do you find yourself thinking about your opioid medication?	☐	☐	☐	☐	☐
7. How often have you been in an argument?	☐	☐	☐	☐	☐
8. How often have you had a problem controlling your anger?	☐	☐	☐	☐	☐
9. How often have you had to take pain medications from someone else?	☐	☐	☐	☐	☐
10. How often are you are worried about how you are handling your pain medications?	☐	☐	☐	☐	☐
11. How often have others been worried about how you are handling your medications?	☐	☐	☐	☐	☐
12. How often have you had to make an emergency phone call or show up without an appointment?	☐	☐	☐	☐	☐
13. How often have you gotten angry with people?	☐	☐	☐	☐	☐
14. How often have you had to make more medication than you are prescribed?	☐	☐	☐	☐	☐
15. How often have you borrowed pain medications from someone else?	☐	☐	☐	☐	☐
16. How often have you used your pain medications for something else besides reducing your pain (sleep, improve mood)?	☐	☐	☐	☐	☐
17. How often have you had to visit the emergency room?	☐	☐	☐	☐	☐