PATIENT MEDICAL HISTORY

NAME:_____ AGE: ____ REFERRING MD: _____

ARE YOU CURRENTLY BEING TREATED BY A PAIN MANAGEMENT DOCTOR [] YES [] NO. IF SO DR. _____

REASON FOR VISIT: _____

HOW LONG HAS THIS BEEN GOING ON : _____ DATE OF ACCIDENT : _____ DATE OF LAST COLONOSCOPY: _____

WEIGHT _____ HEIGHT _____ B/P _____ PULSE _____ TEMP _____ PREGNANT ____ WEEKS HIV STATUS _____

REVIEW OF SYSTEMS

GENERAL: [] WEIGHT CHANGE [] FEVER

EYES: [] WEARS GLASSES/CONTACTS

ENT/ALLERGY: [] HAYFEVER [] CHRONIC RHINITIS

CARDIOVASCULAR: [] LEG SWELLING [] CHEST PAIN
[] CALF PAIN WHEN WALKING [] FOOT PAIN AT REST
[] IRREGULAR HEART RATE

RESPIRATORY: [] CHRONIC COUGH [] COUGHING UP BLOOD
[] SHORTNESS OF BREATH

GASTROINTESTINAL: [] NAUSEA [] DIARRHEA [] CONSTIPATION
[] BLOOD IN STOOL [] INDIGESTION [] ABDOMINAL PAIN

MUSCULOSKELETAL: [] JOINT PAIN [] JOINT SWELLING

SKIN: [] OPEN WOUNDS

NEUROLOGICAL: PARALYSIS []R []L

PSYCHIATRIC: [] MEMORY LOSS

HEMATOLOGIC/LYMPHATIC: [] SWOLLEN GLANDS

URINARY: []BLOOD IN URINE []BURNING WITH URINATION

ENDOCRINE : [] EXCESSIVE THIRST
FEMALES LMP _____

MEDICAL HISTORY (Check If You Have Ever Been Diagnosed)

- ___ ANESTHETIC PROBLEM
- ___ CANCER _____
- ___ GLAUCOMA
- ___ CHANGE IN VOICE
- ___ ANEMIA
- ___ HEART ATTACK
- ___ HIGH BLOOD PRESSURE
- ___ BLOOD CLOT
- ___ LUNG DISEASE _____
- ___ HEART DISEASE _____
- ___ DIABETES
- ___ THYROID DISEASE
- ___ GERD
- ___ HEPATITIS
- ___ CIRRHOSIS
- ___ JAUNDICE
- ___ COLITIS/CROHN'S DISEASE
- ___ GALLSTONES
- ___ KIDNEY STONES
- ___ ENLARGED PROSTATE
- ___ ARTHRITIS
- ___ OSTEOPOROSIS
- ___ PSORIASIS
- ___ BREAST LUMP
- ___ SEIZURES
- ___ STROKE
- ___ MENTAL ILLNESS
- ___ DEPRESSION
- ___ DRUG ABUSE
- ___ ALCOHOL ABUSE
- ___ AIDS
- ___ PNEUMONIA
- ___ OTHER: _____

ARE YOU ALLERGIC TO ANY MEDICATION? (PLEASE INCLUDE REACTION)_____
ARE YOU ALLERGIC TO LATEX? [] YES [] NO

FAMILY HISTORY OF CANCER

	TYPE - LOCATION
FATHER	_____
MOTHER	_____
BROTHERS	_____
SISTERS	_____
CHILDREN	_____

SOCIAL HISTORY

	YES	NO	
ALCOHOL	[]	[]	DAILY [] SOCIAL []
TOBACCO	[]	[]	PPD ___ YRS ____
CAFFEINE USE	[]	[]	FORM _____
WORK STATUS	_____		RETIRED []
OCCUPATION	_____		

LIST ALL MEDICATION INCLUDING OVER THE COUNTER WITH DOSAGE Example Lisinopril 10 mg 1 every day NONE []

1 _____ **2** _____

3 _____ **4** _____

5 _____ **6** _____

7 _____ **8** _____

PREVIOUS SURGERY

	YES	TYPE	DATE		YES	TYPE	DATE
APPENDIX	[]		_____	SPLEEN	[]	_____	_____
BREAST	[]	R[] L [] _____	_____	LIVER	[]	_____	_____
COLON/INTESTION	[]	_____	_____	HEART/LUNG	[]	_____	_____
GALLBLADDER	[]		_____	BLADDER/KIDNEY	[]	_____	_____
HERNIA	[]	_____	_____	GYNECOLOGIC	[]	_____	_____
STOMACH	[]	_____	_____	ORTHOPEDIC	[]	_____	_____
THYROID	[]	_____	_____	VEINS	[]	_____	_____
HEMORRHOIDS	[]	_____	_____	OTHER	[]	_____	_____

PATIENT UPDATE

DATE: _____	_____	_____	_____	**Dialysis Days:** □ M □ W □ F	**DialysisTime:**
INITIAL: _____	_____	_____	_____	**- or -** □ T □ Th □ Sa	**Location:**