ORA ORTHOPEDICS

Patient Name: _____ **Provider:** _____

Date of Birth: _____**Date:** _____

Pain Management History Form

Age: ____ **Sex**: ☐ F ☐ M **Dominant Hand**: ☐ R ☐ L **Height:** _____ **Weight:**_____ **(ORA staff to fill out: P_____R_____)**

Primary Care Doctor's Name: _____

List any other doctors and their specialty that you see:_____

Who requested that you be seen here? ☐ Primary care provider ☐ Emergency room or urgent care provider ☐ yourself ☐ other
Your hospital preference? _____

What problem are you being seen for today? ☐ R ☐ L _____

_____

When did your problem start or what was the date of the injury? _____

What tests/treatments have you had for this problem? ☐ X-Rays ☐ MRI ☐ CT scan ☐ Bone scan ☐ Ultrasound

☐ Nerve Test (EMG/NCV) **When?**_____ **Where?**_____

TREATMENT	WHEN? HOW OFTEN?	WHERE?	WAS IT HELPFUL?
PHYSICAL THERAPY			
CHIROPRACTIC			
BRACE			
TENS UNIT			
EPIDURAL STEROID INJECTION			
MEDICATIONS			
RADIOFREQUENCY ABLATION			
SPINAL CORD STIMULATION			
TRIGGER POINT INJECTION			

Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged

Has your problem kept you from: ☐ Working ☐ Recreational activities ☐ Activities of daily living like cleaning & dressing yourself

I experience: ☐ Pain ☐ Bruising ☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of control bowel/bladder
☐ Locking ☐ Catching ☐ Instability ☐ Swelling ☐ Stiffness ☐ Other _____

If you have pain: How would you describe the type of pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

On a scale of 0 - 10 (10 is the worst) how <u>severe</u> is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10
The pain is: ☐ Constant ☐ Intermittent (comes & goes)
Does the pain radiate/travel/move? ☐ Y ☐ N If yes, where _____
Does your pain wake you from sleep? ☐ Y ☐ N

What makes your symptoms <u>worse</u>? ☐ Walking ☐ Stairs ☐ Exercising ☐ Twisting ☐ Kneeling ☐ Direct pressure
☐ Standing ☐ Sitting ☐ Lying flat ☐ Bending ☐ Lifting ☐ Coughing / sneezing

What makes your symptoms <u>better</u>? ☐ Rest or not moving ☐ Sitting ☐ Lying ☐ Standing ☐ Exercise / movement ☐ Elevation
☐ Ice ☐ Heat ☐ Compression or bracing ☐ Injections ☐ Pain pills ☐ Other medications

If there was a specific injury (including work related injuries), please describe what happened:

(CONTINUE ON OTHER SIDE)>>>>>

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REVIEW OF SYSTEMS

Have you recently had any of these symptoms? Please ☑ check all that apply. If none of the below apply, then mark ☐ NONE.

Skin
☐ Frequent Rashes
☐ Open Wounds
☐ Itchy/Red

Eye
☐ Blurred Vision
☐ Vision Loss
☐ Double Vision

Lung
☐ Short of Breath
☐ Wheezing
☐ Chronic Cough

ENT
☐ Hearing Loss
☐ Hoarseness
☐ Difficulty Swallowing

Digestive
☐ Heartburn
☐ Nausea/Vomiting
☐ Blood in Stool

Blood
☐ Easy Bruising
☐ Easy Bleeding

Neuro
☐ Headaches
☐ Numbness
☐ Weakness
☐ Frequent Falls

Glands
☐ Excessive Thirst
☐ Frequent Urination
☐ Always Hot/cold
☐ Lymphedema

Kidney/Bladder
☐ Painful Urination
☐ Kidney Problems
☐ Urinary Infections

Bones/Joints
☐ Osteoporosis
☐ Joint Problems
☐ Broken Bones

Const
☐ Recent Weight Loss
☐ Frequent Fever
☐ Loss of Appetite

Cardio
☐ Chest Pain
☐ Irregular Beat
☐ Calf Pain
☐ Swelling Feet/Ankle

Psych
☐ Drug Abuse
☐ Alcohol Abuse
☐ Depression
☐ Anxiety

PAST MEDICAL HISTORY

Do you have a history of any of the following: (Please ☑ check all that apply)

Bones/Joints
☐ Broken
☐ Osteoporosis
☐ Arthritis

Heart
☐ Open Heart
☐ Stents
☐ Heart attack
☐ Pacemaker

Circulation
☐ Blood Clots
☐ Clotting Disorders
☐ High Blood Pressure
☐ Stroke
☐ Elevated Cholesterol

Current/Past Infection
☐ Pneumonia
☐ Hepatitis ☐ A ☐ B ☐ C
☐ HIV/Aids
☐ MRSA
☐ VRE

Lung
☐ Asthma
☐ COPD
☐ Emphysema
☐ Sleep Apnea

Glands
☐ Diabetes Type I
☐ Diabetes Type II
☐ Thyroid

Kidney
☐ Infection
☐ Stones

Neuro
☐ Neuropathy
☐ Seizures

Psych
☐ Anxiety
☐ Depression

Digestive
☐ Heartburn
☐ Reflux
☐ Ulcers
☐ Dialysis

Other
☐ Liver Disease
☐ Cancer
☐ _____

List all <u>past surgeries</u> and what year that they occurred: ☐ **NONE** ☐ Appendectomy ☐ Tonsil ☐ Adenoids ☐ C-section/s ☐ Bypass ☐ Gall bladder ☐ Tubes in ear ☐ Hernia repair ☐ Oral surgery ☐ Hysterectomy ☐ Tubal ligation ☐ Orthopedic surgery (please list below)
☐ Others:_____
_____
_____

FAMILY HISTORY

☐ Adopted and family medical history is not known ☐ No significant medical history of any direct relatives

List any major medical problems (examples: diabetes, heart disease, cancer, arthritis …) of your direct relatives:

Mother:_____ Father:_____

Grandparents: _____

Brothers/Sisters:_____ Children:_____

SOCIAL HISTORY

Do you use tobacco? ☐ No ☐ Quit ☐ Yes - How much? _____ **Alcohol use?** ☐ No ☐ Yes – How much? _____

History of substance abuse? ☐ No ☐ Yes

☐ **Student** at _____What grade level_____ Participating in what **sports**?_____

Are you currently working? ☐ Y ☐ N **Type of job:** _____ ☐ Disabled ☐ Retired

Marital Status: ☐ Single ☐ Married ☐ Widowed **Children:** ☐ Y ☐ N **Are you pregnant?** ☐ Y ☐ N ☐ Unknown

(CONTINUE ON OTHER SIDE)>>>>>

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Are you allergic to any medications? ☐ Y ☐ N If yes, please list below and list the reaction (hives/stopped breathing/rash/swelling):

_____

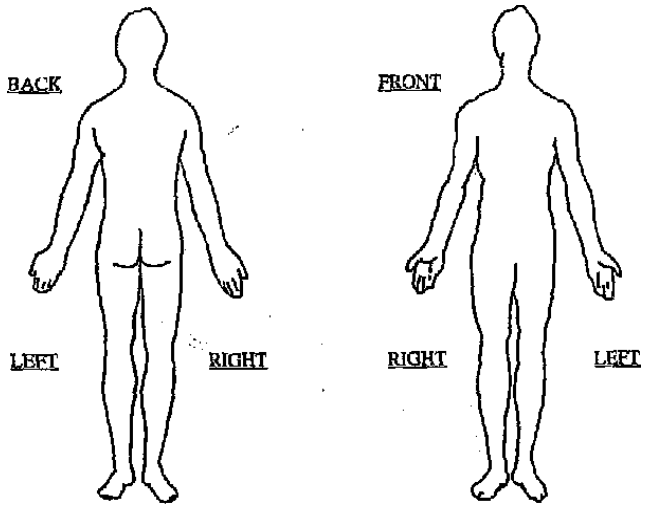
☐ **Other Allergies:** ☐ Latex ☐ Food ☐ Seasonal ☐ Metal ☐ Other **Have you ever had a reaction to anesthesia?** ☐ Y ☐ N _____

Current Medications, the dose and frequency (list all prescription and over the counter medications/supplements):

_____
_____
_____
_____
_____
_____
_____
_____
_____

Mark the areas on your body where you feel pain using the following symbols:

Aching	Numbness	Tingling	Pins and Needles	Burning	Stabbing
△△△	===	0000	+++	X X X	/ / /



Patient Signature The information on this form is accurate to the best of my knowledge. **Date**

FOR OFFICE USE ONLY: (Initial and date when completed and with each update)

Review#1 by: Date Review #2 by: Date