



Interventional Pain Management and Spine Treatment

Please answer completely

(Check, circle, or write in all that apply to you)

PATIENT QUESTIONNAIRE

Your Name :
Your Date of Birth:

Referring MD:
Primary Care MD:

Describe the pain or discomforting symptoms you are experiencing.

Describe your pain: aching burning cramping cutting dull excruciating grinding increasing
(circle all that apply) intense intolerable itching just tolerable like an electric shock moderate
numb piercing pulsing severe sharp shooting squeezing
stabbing stinging strong throbbing tingling uncomfortable weak

When did your pain start? (month/year) Did it increase recently? Yes No

How did the pain start? Auto accident Work related Following surgery Fall
Just Started Other

When does your pain occur? constant intermittent (off & on) early AM PM
at rest walking sitting standing lying down

Do you have numbness/tingling? No Yes in Fingers Right Left / Toes Right Left

Does your pain move to other parts of your body? No Yes Neck to arm Right Left
Back to leg Right Left

How many times a night do you wake up because of pain?

Circle the numbers below that best describe how pain has interfered with your daily functioning

0 = Does not interfere 10 = Completely interferes

Table with 11 columns (0-10) and 8 rows (General activity, Walking ability, Normal work routine, Normal home routine, Sleep, Enjoyment of life, Relations with other people, Mood)

Primary language

Is a lawyer involved w

If 0 = no pain and 10 = the worst pain I can imagine, what is the highest number I can live with and still function.

0 1 2 3 4 5 6 7 8 9 10

Riverhills Interventional Pain Management Patient Questionnaire

Page 2 of 6

Do you take Blood thinners?

If yes, Coumadin Plavix Pletal Lovenox

Name of MD managing Blood thinner Phone #

Have you ever fainted or passed out with needles or procedures?

ALLERGIES: Iodine Xray Dye Shellfish Latex Beestings

(please list all other medication, environmental, food allergies)

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**FAMILY HISTORY****Have Parents, Grandparents or Siblings had any of the following medical conditions?**

- Back Problems  Neuropathy  Pain Syndromes  Depression  Alcoholism  Diabetes  Hypertension  Heart Disease  
 Stroke  Cancer  High Cholesterol  Other \_\_\_\_\_  
 No significant family history
- 

**PAST MEDICAL HISTORY** (Check or circle all that apply to you).

- Diabetes ( Insulin  Oral Meds.  Diet Control)  Addison's disease  Hypothyroidism  Hyperthyroidism  
 COPD  Emphysema  Asthma: Last attack \_\_\_\_\_  History of TB  Sleep Apnea  Uses C PAP at night  
 Hypertension  Angina  History of MI, when \_\_\_\_\_  Cardiac Stents # \_\_\_\_\_  Carotid Artery Disease  
 Shunts  Pacemaker  Defibrillator  Artificial valve  Coronary Artery Disease  
 Peripheral vascular disease (PVD) - Legs  Anemia  History of Hepatitis ( A  B  C)  HIV/AIDS  
 Liver Disease  Gallbladder Disease  Heartburn  Reflux  GERD  Hiatal Hernia  Esophageal Stricture  
 Stroke, when \_\_\_\_\_  Alzheimer's disease  Parkinson's disease  Multiple Sclerosis  
 Psoriasis  Shingles

**Cancer History**

Type \_\_\_\_\_ Date(s): \_\_\_\_\_

Treatment:  Surgery \_\_\_\_\_  Radiation  Chemotherapy**REVIEW OF SYSTEMS** (Check or circle all that apply to you).**General Health**

- Change in appetite  Recent weight loss \_\_\_\_\_ lbs.  Recent weight gain \_\_\_\_\_ lbs.  
 Fatigue  Chronic Fevers  Other \_\_\_\_\_

**Head, Eyes, Ears, Nose, Throat (HEENT)**

- Hearing loss  Hearing aid (Right / Left)  Tinnitus (Ringing/Buzzing in ears)  Cataracts  Glaucoma  
 Double Vision  Blurred Vision  Macular Degeneration  Glasses / Contacts  
 Dentures ( Upper / Lower )  Partials ( Upper / Lower )  Loose teeth  
 Nasal Septal Deviation  Sinus Problems ( Seasonal / All Year )  Other \_\_\_\_\_

**Endocrine**

- Excessive thirst or urination  Excessive Appetite  Other \_\_\_\_\_

**Respiratory (Lungs and Breathing)**

- Shortness of breath  Chronic Cough  Coughing Blood  Breathing Treatments  Home Oxygen  
 Snoring  Other \_\_\_\_\_

**Cardiovascular**

- Chest Pain - last episode \_\_\_\_\_  Heart Murmur  CHF  Palpitations  Irregular Heartbeat  
 History of Rheumatic Fever  High Cholesterol  History Blood Clots

**Riverhills Interventional Pain Management Patient Questionnaire**

Page 3 of 6

**Hematologic/Lymphatic**

- Bleeding disorder \_\_\_\_\_  Excessive Bleeding  Lymph Node Swelling  
 Factor deficiency (type) \_\_\_\_\_  Lymph Node Swelling

**Gastrointestinal**

- History of Ulcer (date) \_\_\_\_\_  Gastric Bypass  Lap Band  Bleeding from stomach / bowels  
 Irritable Bowel Syndrome (IBS)  Diverticulosis  Crohn's Disease  Ulcerative Colitis  
 Chronic Diarrhea  Chronic Constipation  Colostomy  Ileostomy  Other \_\_\_\_\_

**GenitoUrinary**

- Kidney pain  Burning  History of Kidney Stone  Frequency  Urgency  Hesitancy  Incontinence  
 Chronic Infections  Dialysis  Ureterostomy  Catheter (Type) \_\_\_\_\_  Prostate Enlargement  
 LMP \_\_\_\_\_  Menopausal  Hysterectomy, when \_\_\_\_\_  Tubal Ligation  
 Uterine Ablation  Birth Control (Type) \_\_\_\_\_  Sexual Difficulty  Other \_\_\_\_\_

**Neurological**

- Dizziness  Fainting  Headaches (How often) \_\_\_\_\_  Seizures, last seizure \_\_\_\_\_  
 TIA  Paralysis ( Right / Left )  Weakness ( Right / Left )  Problems with Speech  
 Tremors  Confusion  Problems with memory  History of Head Injury (Date) \_\_\_\_\_  History of falls  
 Incoordination  Numbness (Location) \_\_\_\_\_  Tingling (Location)  Other \_\_\_\_\_

**Musculoskeletal**

- Back pain  Neck pain  other pain (Location) \_\_\_\_\_  Arthritis ( Rheumatoid / Osteo )

- Osteoporosis  Scoliosis  Spinal Stenosis  Fibromyalgia
- Joint replacement(Location) \_\_\_\_\_  Artificial limb(Location) \_\_\_\_\_
- Amputation(Location) \_\_\_\_\_  Other \_\_\_\_\_

**Skin**

- Eczema  Sores  Rash  Bruises  Cuts  Burns  Incision  Itching
- Dry Skin  Lumps  Ulcers  Abscess  Cellulitis  Other \_\_\_\_\_

**Psychosocial**

I live :  alone with  spouse  significant other  Parent(s)  Sibling(s)  Friend(s)  
 Other relative \_\_\_\_\_  Children # \_\_\_ Ages \_\_\_\_\_  Grandchildren # \_\_\_ Ages \_\_\_\_\_

My residence is:  House, condo, apartment  Retirement or Independent Living  Assisted Living  
 Nursing Care Facility  Shelter  Other \_\_\_\_\_

Are you working at this time? \_\_\_ Yes \_\_\_ No \_\_\_ Retired \_\_\_ Workers' Comp \_\_\_ Disabled

Your current occupation or occupation before retired or disabled: \_\_\_\_\_

Primary language \_\_\_\_\_

Is a lawyer involved with your pain situation? \_\_\_ Yes \_\_\_ No Name : \_\_\_\_\_

<p><b>Tobacco:</b> _____</p> <input type="checkbox"/> Never <input type="checkbox"/> Former - Stop Date: _____ <input type="checkbox"/> Use Smokelss Tobacco <input type="checkbox"/> Current Smoker How much/day? _____ How many Years? _____	<p><b>Alcohol:</b> _____</p> <input type="checkbox"/> Never <input type="checkbox"/> Former - Stop Date: _____ <input type="checkbox"/> Current Drinker <input type="checkbox"/> Rare <input type="checkbox"/> Occassional <input type="checkbox"/> Drinks /day <input type="checkbox"/> Drinks/ week	<p><b>Recreational Drugs:</b> _____</p> <input type="checkbox"/> Never <input type="checkbox"/> Former- Stop Date: _____ What was used? _____ <input type="checkbox"/> Current User <input type="checkbox"/> Marijuana <input type="checkbox"/> Other: _____
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**Psychosocial (continued)**

- History of depression  History of Bipolar Disease  History of Schizophrenia  Anxiety  Panic Attacks
- ADHD  History of abuse by another person ( Past / Current )  Suicidal thoughts / attempts, when \_\_\_\_\_
- Seeing psychologist/psychiatrist(Name) \_\_\_\_\_

**What Tests or Diagnostic Studies have you had related to your problem?**

	When	Where
MRI(s) <input type="checkbox"/> Back <input type="checkbox"/> Neck <input type="checkbox"/> Hip <input type="checkbox"/> Shoulder CT Scan Xrays Myelogram EMG/Nerve Conduction Bone Scan Other		

**Previous Treatments you have had for this problem:**

- Physical therapy
- Aquatic therapy
- Biofeedback
- Decompression Therapy
- Chiropractor
- Injections or nerve blocks- When? \_\_\_\_\_  
     How Many? \_\_\_\_\_  
     What Type? \_\_\_\_\_
- TENS
- Home exercise
- Pain Psychologist
- Nutrition counseling
- Pain Management- Name of MD or Clinic \_\_\_\_\_
- Occupational therapy
- Massage therapy
- Hypnosis
- Acupuncture

List all medicines you have tried in the past for this condition (Prescription and over-the-counter).

**Surgical History ( List all past surgeries and Dates)**

**What Medicines are you currently taking?**

(Please include all prescriptions, over-the-counter medicines, herbals, vitamins, and natural products.)

<u>Name of Medicine</u>	<u>Dose/Frequency</u>	<u>Reason taking</u>	<u>Prescribing MD</u>
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Information is complete and accurate.

Patient Signature: \_\_\_\_\_

Signature of person completing forms: \_\_\_\_\_

For: (Patient Name) \_\_\_\_\_

Riverhills Interventional Pain Management Patient Questionnaire

Page 6 of 6

### PAIN MAP

Please shade/draw in where your pain is located on the figures



