Hudson Valley
PAIN MANAGEMENT

Patient History Form for Current Visit

Patient Name____________________________________ Today's Date______________ Date of Birth__________________

What medical concerns can we assist with today?

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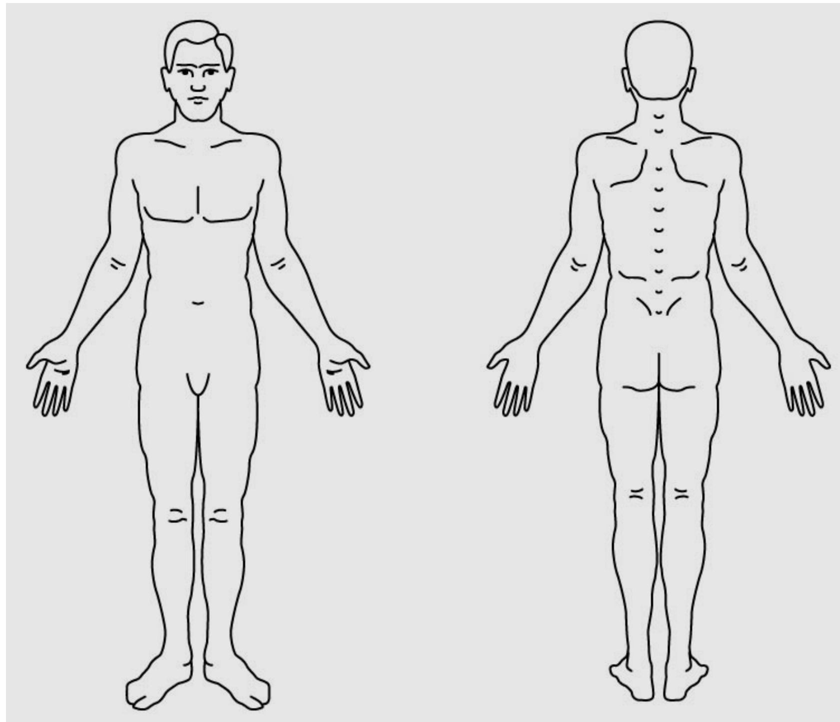
On the diagram, shade in the areas where you feel pain. Place an X where the pain hurts the most.



Medical History (Please list all current and previous medical conditions, ex. Heart disease, diabetes, etc.)

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Surgical History (Please list all previous surgeries)

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Current Medications:

Medication	Dose (mg/mcg)	Number of times taken daily

Are you allergic to any medications? Yes No
If yes, to which medications? ____________________

Social History
Do you currently smoke or chew tobacco? Yes No If no, have you in the past? Yes No
How many packs per day? ____________________

Do you drink alcohol, beer, or wine? Yes No If no, have you in the past? Yes No
How many drinks per week? ____________________

Do you have any history of illegal drug use? Yes No If yes, last time used? ____________________
If yes, which ones? ____________________

Are you employed? Yes No Occupation? ____________________
Are you currently receiving or applying for disability? Yes No

Are you currently involved in any lawsuits related to your pain? Yes No
If yes, please explain. ____________________

Family History

	Living		Age (or age at death)	List serious illnesses
Mother	Yes	No	________	________
Father	Yes	No	________	________
Sisters	Yes	No	________	________
	Yes	No	________	________
	Yes	No	________	________
Brothers	Yes	No	________	________
	Yes	No	________	________
	Yes	No	________	________