Hudson Valley
PAIN MANAGEMENT

Patient History Form for Current Visit

Patient Name_____ Today's Date_____ Date of Birth_____

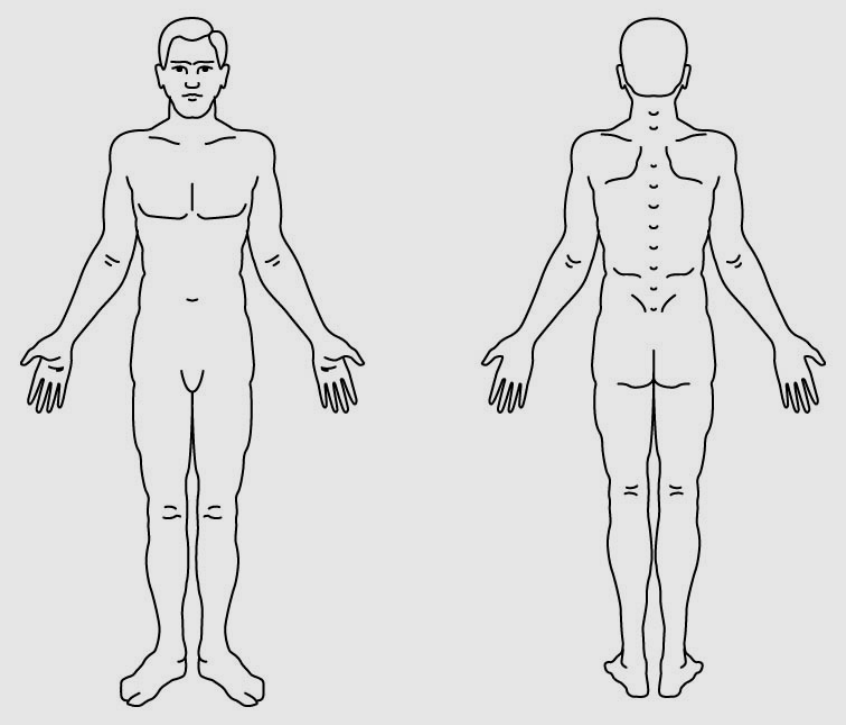
What medical concerns can we assist with today?

_____

_____

_____

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



When did your pain begin? _____

Which best describes your pain (circle all that apply)?

Sharp Dull Burning Aching Throbbing Shooting Constant Intermittent Electrical

What activities increase your pain?

_____

Please rate the intensity of your pain today:

|------0------1------2------3------4------5------6------7------8------9------10------|
Mild Moderate Severe

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

_____

_____

Surgical History (Please list all previous surgeries)

_____

_____

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	_____	_____

Do you suffer from any of the following symptoms?

	Yes	No
Constitutional:		
Fever	☐	☐
Fatigue	☐	☐
Difficulty Sleeping	☐	☐
Weight loss	☐	☐
Eyes:		
Visual Changes	☐	☐
Cardiac:		
Chest Pain	☐	☐
Palpitations	☐	☐
Respiratory:		
Cough	☐	☐
Shortness of Breath	☐	☐
Gastrointestinal:		
Diarrhea	☐	☐
Nausea	☐	☐
Constipation	☐	☐
Incontinence of Stool	☐	☐

	Yes	No
Genitourinary:		
Urinary Retention	☐	☐
Urinary Incontinence	☐	☐
Painful Urination	☐	☐
ENT:		
Headache	☐	☐
Hearing Loss	☐	☐
Musculoskeletal:		
Weakness	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
Neurological:		
Numbness	☐	☐
Dizziness	☐	☐
Psychological:		
Depression	☐	☐
Anxiety	☐	☐