

PAIN CONSULTANTS OF ARIZONA IN COLLABORATION WITH HONOR HEALTH

Patient History Form

Date: _____

Patient Name: _____ DOB: _____

Who referred you to see us? _____

Chief Complaint: What is the main reason for your visit today?

History of Present Illness

Please answer the following questions:

Where is your worst pain? On the diagram to the right, best mark your **MOST** painful area (s) and describe briefly below.

When did you first notice the problem?

Cause (if known):

- Work Injury Illness Vehicular Accident
 Other _____

Does anything help or make the problem worse?

- Sitting Standing Walking
 Lying down Sneezing/coughing Exercising

Other: _____

Associated Symptoms:

- Weakness Poor Sleep Mood changes Bladder/bowel incontinence

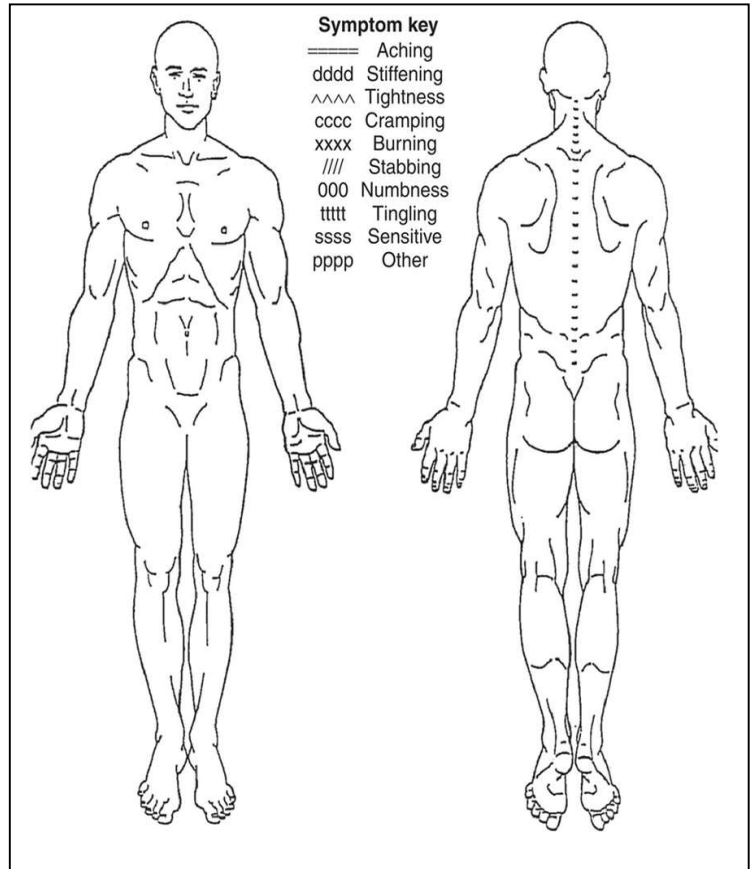
How long does the problem last?

- Minutes Hours Intermittent Constant
Other _____

Is there anything else occurring at the same time?

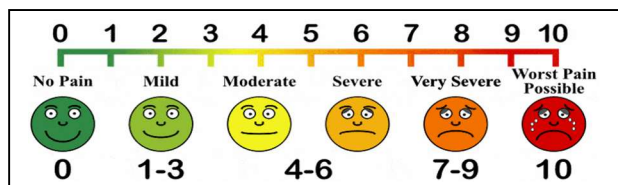
- Yes No

If yes, explain:



Average pain level: _____/10

Current pain level: _____/10



PAST MEDICAL HISTORY:

- | | | | | | |
|-----------------------|------------------------------|-----------------------------|--------------------------------|------------------------------|-----------------------------|
| Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Arrhythmia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | COPD | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neuropathy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sleep Apnea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver disease/problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blood clots/pulmonary embolism | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rheumatoid Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| GERD/Gastritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney disease/problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Psychiatric Condition | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

If yes for any, briefly explain/describe the condition(s):

Previous Hospitalizations/Surgeries/Serious Illness (and dates if known): _____

Please list all **MEDICATIONS** you are currently taking and dose if known: (If you need more space, please use a separate sheet or you may provide us your own list).

Please list any **ALLERGIES** (and reactions): NONE

Allergic to: Iodine or IV contrast Latex Local Anesthetics None of these.

Do you have a pacemaker, defibrillator, or other implantable electronic devices? **Yes / No**

If yes, please describe: _____

Are you on blood thinners? Yes No

If yes, which blood thinners are you taking?

- COUMADIN PLAVIX PRADAXA AGGRENOX ELIQUIS
- XARELTO PLETAL TICLID EFFIENT BRILINTA

OTHER: _____

SOCIAL HISTORY:

Marital Status: Single Married Separated
 Divorced Widowed

Occupation: **What is/was your primary occupation?**

Full-time Part-time Retired
 Not working Disabled Student

Use of Alcohol: Never Rarely Occasional Daily

Use of Tobacco:

Cigarettes Yes No
Smokeless Tobacco Yes No

Use of Illicit Drugs:

Current Yes No Explain: _____
Past Yes No Explain: _____

Use of Marijuana

Current Yes No Explain: _____
Past Yes No Explain: _____

If yes, do you have a current State of Arizona-issued Medical Marijuana Card? Yes No