**PAIN CONSULTANTS OF ARIZONA IN COLLABORATION WITH HONOR HEALTH**

**Patient History Form**

**Date:** _____

**Patient Name:** _____ **DOB:** _____

**Who referred you to see us?** _____

**Who is your PCP?** _____

**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: _____

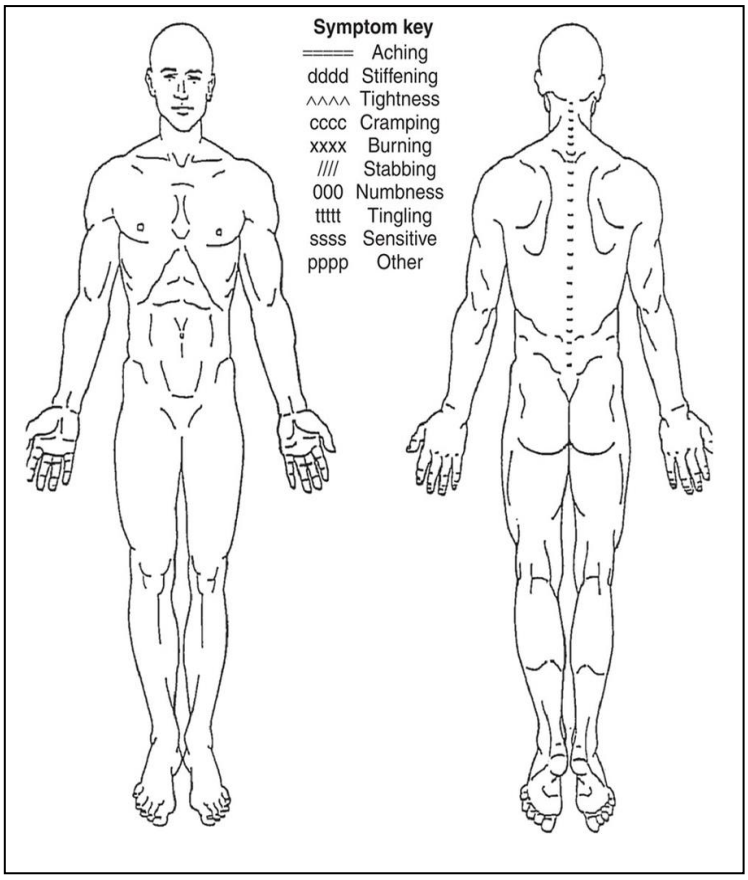
**Associated Symptoms:**

❑Weakness ❑ Poor Sleep ❑ Mood changes ❑Bladder/bowel incontinence

**How long does the problem last?**

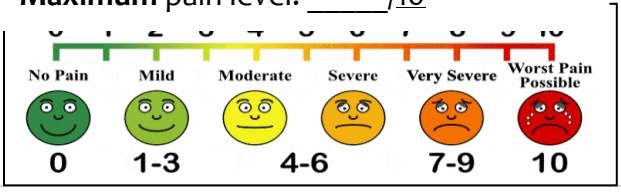
❑ Minutes ❑ Hours ❑ Intermittent ❑ Constant
Other_____

_____
_____
_____




**Average** pain level: _____/10

**Maximum** pain level: _____/10



## PAST MEDICAL HISTORY:

| | | | | | |
|---|---|---|---|---|---|
| **Heart Disease** | ❑Yes | ❑No | **Heart Arrhythmia** | ❑Yes | ❑No |
| **High blood pressure** | ❑Yes | ❑No | **Stroke** | ❑Yes | ❑No |
| **Seizures** | ❑Yes | ❑No | **COPD** | ❑Yes | ❑No |
| **Asthma** | ❑Yes | ❑No | **Neuropathy** | ❑Yes | ❑No |
| **Sleep Apnea** | ❑Yes | ❑No | **Liver disease/problems** | ❑Yes | ❑No |
| **Bleeding disorder** | ❑Yes | ❑No | **Blood clots/pulmonary embolism** | ❑Yes | ❑No |
| **Rheumatoid Arthritis** | ❑Yes | ❑No | **Gout** | ❑Yes | ❑No |
| **GERD/Gastritis** | ❑Yes | ❑No | **Kidney disease/problems** | ❑Yes | ❑No |
| **Psychiatric Condition** | ❑Yes | ❑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