Patient Name _____ DOB _____

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PAIN DESCRIPTION AND HISTORY-page 1 of 4

WHERE ARE YOUR WORST 2 PAIN COMPLAINTS TODAY?

_____

PLEASE RATE YOUR AVERAGE PAIN OVER THE PAST MONTH ON A SCALE FROM 1-10 FOR EACH:

_____

Pain Score (0-10)

Now _____ At rest _____ With activity _____

When did your pain start? _____

Description of pain: _____

HOW DOES YOUR PAIN FEEL?

___ Sharp ___ Dull ___ Aching ___ Burning

___ Cramping ___ Pressure ___ Stabbing

___ Electrical Shock ___ Shooting ___ Numbness

___ Tingling ___ Other _____

___ Constant ___ Intermittent

NUMBNESS OR TINGLING LOCATION? _____

WHAT CAUSED YOUR PAIN?

___ Injury at work ___ Injury at home

___ Following an illness ___ Following a surgery

___ Started all of a sudden – no cause

___ Came on gradually/gradually worsened

___ Other _____

WHICH TREATMENTS HAVE YOUR TRIED?

___ Biofeedback ___ Herbal Remedies

___ Yoga ___ Massage

___ Surgery ___ TENS unit

___ Acupuncture ___ Water Therapy

___ Spinal Cord Stimulator Surgery

___ Medications ___ Ice Pack

___ Heating Pad ___ Exercise program

___ Physical Therapy ___ Implantable Device

___ Comprehensive Pain Program

___ Injection: When? _____

__ Other _____

WHAT MAKES YOUR PAIN WORSE?

___ Sitting ___ Standing

___ Coughing/Sneezing ___ Walking

___ Lying on stomach ___ Sleeping

___ Weather changes ___ Driving/Travel

___ Bending/twisting

___ Other: _____

_____

WHAT MAKES THE PAIN BETTER?

_____

WHAT PHARMACY DO YOU USE? _____

HAVE YOU TAKEN ANY ANTICOAGULANT (BLOOD THINNER OR ASPIRIN) MEDICINE IN THE LAST 3 MONTHS?

___ Yes ___ No *If yes*, Name of drugs: _____For What? _____

Please list all medicines you take which require a doctor's prescription: (Please attach additional sheet if needed)

Name of Medicine	Dose of Medicine/Frequency	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name _____ DOB _____

ALLERGIES: (Such as: Medicine, Latex, Food, Tape, Perfume)

___ No Allergies

ALLERGY	TYPE OF REACTION	ALLERGY	TYPE OF REACTION
_____	_____	_____	_____
_____	_____	_____	_____

LIST SURGERIES (INCLUDE DENTAL) INJURIES, HOSPITALIZATIONS & PROCEDURES NOT LISTED ON PREVIOUS PAGES:

Date: _____ Procedure: _____

Date: _____ Procedure: _____

Date: _____ Procedure: _____

Date: _____ Procedure: _____

MEDICAL HISTORY

LUNGS AND RESPIRATORY: ___ **None**

___ Emphysema ___ Cough/Cold

___ Asthma/Wheezing ___ Sleep Apnea

___ Pneumonia

___ Other _____

HEART AND VASCULAR: ___ **None**

___ Heart Failure ___ Angina/Chest pain

___ High Blood Pressure ___ Pacemaker

___ Irregular Heart Beat ___ Valve Disease

___ High Cholesterol

GENITO/URINARY: ___ **None**

___ Kidney Stones ___ Kidney, Renal or

___ Urinary Catheter Urinary Tract Disease

___ Dialysis: last date: _____

___ Other _____

GASTROINTESTINAL: ___ **None**

___ Rectal Bleeding ___ Liver Disease

___ Ulcers ___ Nausea/Vomiting

___ Pancreatitis

___ Other _____

PSYCHOLOGIC: ___ **None**

___ Depression ___ Sleep Disturbance

___ Anxiety ___ Suicidal Thoughts

HEMATOLOGIC: ___ **None**

___ Bruising ___ Hepatitis

___ Blood clotting abnormalities

___ Easy Bleeding ___ Anemia

___ Other: _____

NERVOUS SYSTEM: ___ **None**

___Stroke ___Dizziness

___ Numbness/weakness ___ Falls

___ Fainting spells/Blackouts ___ Head/Neck Injury

___ Seizure/Epilepsy ___ Headaches

___ Other _____

MUSCULAR-SKELETAL SYSTEM: ___ **None**

___ Muscle/Joint Pain ___ Arthritis

___ Chronic Back/Neck Trouble ___ Multiple Sclerosis

___ Unusual Muscle Weakness ___ Paralysis

___ Autoimmune Disorder ___Fibromyalgia

___ Other _____

ENDOCRINE: ___ **None**

___Diabetes ___ Thyroid Problems

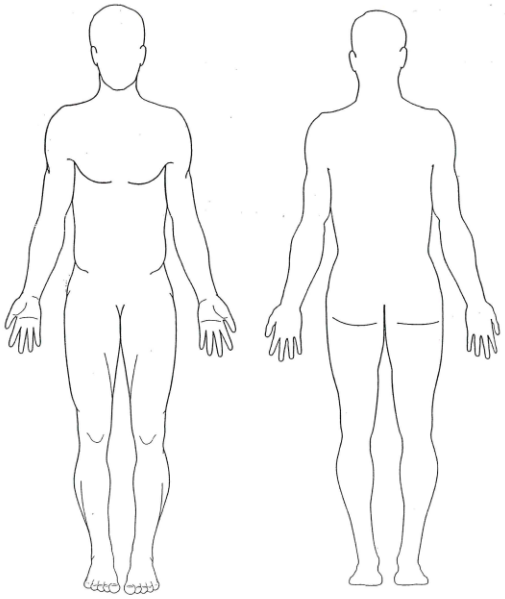
___ Sweats/Chills ___ Low Blood Sugar

___ Other _____

Yes	**No**	
___	___	Do you use tobacco ___ Cigarettes __ packs/day ___Cigars ___ Pipe ___ Chew (quit_____) Years used ___
___	___	Do you use alcohol? How much? _____ Last drink _____ Recovering Alcoholic _____
___	___	Marijuana or other street drugs? What_____ How often _____

Patient Name _____ DOB _____

PLEASE FILL IN THE DIAGRAM BELOW INDICATING THE TYPE OF PAIN/SENSATIONS YOU ARE HAVING AND THE LOCATION ON YOUR BODY:



Review of Systems (PATIENTS PLEASE COMPLETE)

Please circle all current problems: _____

General: fever / chills / other _____

Eyes: blurring / double vision / other _____

Ear, nose and throat: ear pain / nasal congestion / other _____

Lungs: shortness of breath / cough / other _____

Heart: chest pain / palpitations / other _____

Gastrointestinal: nausea / vomiting / other _____

Genitourinary: painful urination / new issue with loss of bladder control / other _____

Hematology: bruising tendency / bleeding tendency / other _____

Endocrine: excessive thirst / excessive urination / other _____

Immunologic: recurrent fevers / recurrent infections / other infections _____

Musculoskeletal: back pain / neck pain / joint pain / muscle pain / other _____

Integumentary: rash / abrasions / other _____

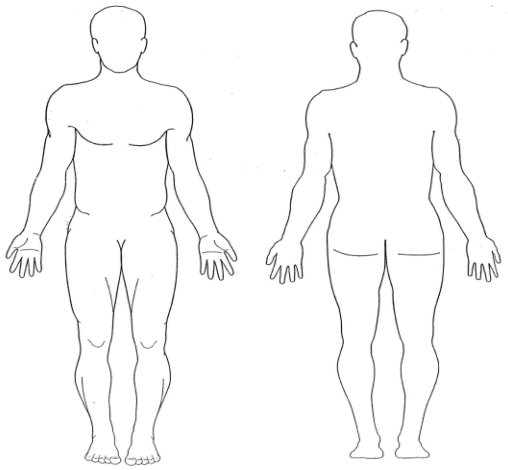
Neurologic: confusion / numbness / other _____

Psychiatric: anxiety / depression / other _____

Patient Name _____ DOB _____

FOR OFFICE USE ONLY BELOW THIS LINE.

History and Physical Note



Physical Exam:

General/Orientation: l A&O x3 l No acute distress l other _____

Extremities: l No cyanosis/clubbing l No edema l other _____

Respiratory: l Clear to auscultation l Unlabored l other _____

Cardiac: l Regular rate and rhythm l No murmur l other _____

Abdominal: l Nondistended l soft l other_____

Skin: l Clean l Dry l Intact l other _____

Musculoskeletal: _____

Neuro: _____

Anesthesia Plan: (✓) one: _____Local anesthesia _____Mild/Moderate Sedation(ASA Classification:_____)

Assessment/Plan:_____

Follow up: _____

Orders: _____

The patient is an appropriate candidate to undergo the planned procedure and selected anesthesia in the ambulatory setting: l Yes l No

Review of systems on back page reviewed: ____Yes _____No

Physician Signature _____ Date (m/d/y) _____ /_____ /_____ Time _____