**SunCoast Pain Management, P.A.**
**History of Present Illness & Chief Complaint**

**Date:** _____

**Name:** _____ **Age:** _____

**Referring Physician(s):** _____

**Other physicians seen for this problem:** _____

**Have you ever seen another pain management doctor?** Yes No

If yes, please list all their names. _____

**How long have you had this pain?** _____

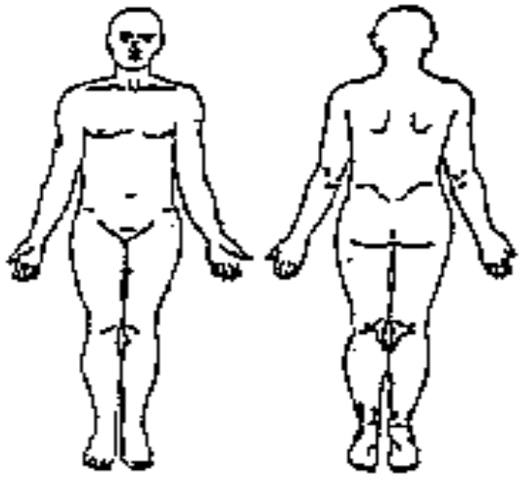
**Is your pain the result of an:**

| | | | If Yes, explain and give details |
|---|---|---|---|
| **Illness** | Yes | No | _____ |
| **Accident** | Yes | No | _____ |
| **Other** | Yes | No | _____ |

**Are you presently involved in a lawsuit resulting from an accident?** Yes No

If Yes, what is the name of your attorney? _____

**Please shade in the areas of the diagrams where your pain is located.**



**Please circle the appropriate words that best describe your pain.**

| | | | |
|---|---|---|---|
| Aching | Cramping | Numbing | Stabbing |
| Annoying | Excruciating | Radiating | Stinging |
| Brief | Dull | Severe | Tight |
| Burning | Heavy | Sharp | Tingling |
| Coldness | Hotness | Shooting | Transient |
| Constant | Intense | Soreness | Unbearable |

**The following lines represent a pain of increasing intensity from "no pain" to "worst pain imaginable". Circle the line to best describe:**

**The average intensity of your pain this week:**

| | 0 | | | | | | | | | 10 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| no pain | I | I | I | I | I | I | I | I | I | I | worst pain imaginable |

**Your pain at its worst:**

| | 0 | | | | | | | | | 10 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| no pain | I | I | I | I | I | I | I | I | I | I | worst pain imaginable |

**Your pain at its least:**

| | 0 | | | | | | | | | 10 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| no pain | I | I | I | I | I | I | I | I | I | I | worst pain imaginable |

**Patient assessment of stress:**

| | 0 | | | | | | | | | 10 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| no stress | I | I | I | I | I | I | I | I | I | I | worst stress imaginable |

**Please indicate if the following increases, decreases or causes no change in your pain:**

| | Increases Pain | Decreases Pain | No Change |
|---|---|---|---|
| Bowel Movements | ☐ | ☐ | ☐ |
| Bright Lights | ☐ | ☐ | ☐ |
| Cold | ☐ | ☐ | ☐ |
| Damp | ☐ | ☐ | ☐ |
| Distraction (TV, etc.) | ☐ | ☐ | ☐ |
| Eating | ☐ | ☐ | ☐ |
| Fatigue | ☐ | ☐ | ☐ |
| Heat | ☐ | ☐ | ☐ |
| Liquor | ☐ | ☐ | ☐ |
| Loud Noises | ☐ | ☐ | ☐ |
| Lying Down | ☐ | ☐ | ☐ |
| Massage | ☐ | ☐ | ☐ |
| Movement | ☐ | ☐ | ☐ |
| Physical Activity | ☐ | ☐ | ☐ |
| Pressure | ☐ | ☐ | ☐ |
| Sexual Intercourse | ☐ | ☐ | ☐ |
| Sitting | ☐ | ☐ | ☐ |
| Sleep, Rest | ☐ | ☐ | ☐ |
| Sneezing, Coughing | ☐ | ☐ | ☐ |
| Standing | ☐ | ☐ | ☐ |
| Tension | ☐ | ☐ | ☐ |
| Urination | ☐ | ☐ | ☐ |
| Weather Changes | ☐ | ☐ | ☐ |

**Please circle all medications taken specifically for THIS PAIN PROBLEM at any time.**

Advil
Alleve
Ambien
Amitriptyline
Anaprox
Atarax
Baclofen
Benadryl
Bufferin
Cafergot
Celebrex
Celexa
Clonazepam
Codeine
Compazine
Cymbalta
Darvocet
Darvon
Daypro
Demerol
Dexamethasone
Dilantin
Dilaudid
Doxepin
Duragesic
Effexor
Elavil
Empirin
Equagesic
Ergotrate
Excedrin
Feldene
Fiorinal
Fiorinal w/Codeine
Flexeril
Gabapentin
Haldol
Heroin
Hydrocortisone
Ibuprofen
Imitrex
Indocin
Kadian
Klonipin
Lexapro
Librium
Lidoderm Patches
Lithium
Lorcet
Lortab
Lunesta
Lyrica
Marijuana
Marinol
Mepergan
Methadone
Mexilitine
Morphine
MS Contin
MSIR
Naproxyn
Neurontin
Nortriptyline
Opana
Oxycontin
Pamelor
Parafon Forte
Paxil
Percocet
Percodan
Phenaphen
Phenaphen w/Codeine
Phenobarbital
Prednisone
Prozac
Quaalude
Relafen
Restoril
Ritalin
Robaxin
Roxicodone
Skelaxin
Soma
Suboxone
Talwin
Tegretol
Toradol
Tramadol
Trazadone
Tylenol
Ultracet
Ultram
Valium
Valproic Acid
Vicodin
Vioxx
Vistaril
Xanax
Zoloft
Zostrix

**Please Check any of the following treatments you have had for THIS PAIN PROBLEM. Include the dates and results.**

| Treatment | | | Pain Relief | | Date/Results |
|---|---|---|---|---|---|
| Acupuncture | Yes | No | Yes | No | _____ |
| Chiropractor | Yes | No | Yes | No | _____ |
| Hypnosis, Biofeedback | Yes | No | Yes | No | _____ |
| Nerve Block/Epidural Steroids | Yes | No | Yes | No | _____ |
| Pain Clinic | Yes | No | Yes | No | _____ |
| Physical Therapy | Yes | No | Yes | No | _____ |
| Psychiatrist, Psychologist | Yes | No | Yes | No | _____ |
| TENS Unit | Yes | No | Yes | No | _____ |

**Please indicate which diagnostic procedures (tests) you have had for THIS PROBLEM:**

| | | | **Date and Location** |
|---|---|---|---|
| CT-Scan | Yes | No | |
| EMG & Nerve Conduction | Yes | No | |
| Myelogram | Yes | No | |
| MRI Scan | Yes | No | |
| X-ray | Yes | No | |

**ALLERGIES:**

☐ No known drug allergies

☐ Yes Medication _____
Reaction _____

☐ Yes Medication _____
Reaction _____

☐ Yes Medication _____
Reaction _____

☐ Yes Medication _____
Reaction _____

Are you allergic to any foods? Yes No If yes, which food _____

Are you allergic to IVP dye, shell fish, or latex? Yes No

**Please list all medications (prescription and non-prescription) you are currently taking.**
**Please indicate the doctor who prescribed them.**

| Medication | Dosage | How Often | Doctor |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Please circle symptoms you currently have or have had in the past year.**

**CONSTITUTIONAL**
chills
fatigue
fever
night sweats
weight gain
weight loss

**EYES**
blurred vision
eye drainage
eye pain
glasses/contacts
photophobia

**EARS/NOSE/THROAT**
ear pain
hearing problems
ringing in the ears
nosebleeds
nasal congestion
runny nose
bleeding gums
periodontal disease
dentures
hoarseness
sore/ulcers in mouth
sore throat
tooth pain

**CARDIOVASCULAR**
chest pain

**FAMILY HISTORY**
cramping in legs with walking
dizziness
shortness of breath with lying down
palpitations
leg swelling
fast heart rate at rest
varicose veins

**RESPIRATORY**
cough (acute)
cough (chronic)
shortness of breath
exposure to TB
coughing blood
chest pain with breathing
wheezing

**GASTROINTESTINAL**
abdominal pain
acid reflux
anorexia
bloating
difficulty swallowing
constipation
diarrhea
heartburn
vomiting blood
hemorrhoids
nausea
vomiting
pain swallowing

**GENITOURINARY**
painful urination
genital lesions
blood in urine
frequent UTIs
impotence
frequent urination
urinary incontinence

**MUSCULOSKELETAL**
joint pain
back pain
neck pain
joint stiffness
limb pain
muscular pain

**INTEGUMENTARY**
atypical moles
dry skin
jaundice
itching
rashes

**NEUROLOGICAL**
dizziness
fainting
headaches
memory loss
skin numbness or tingling
seizures
tremors
vertigo
weakness

**HEMATOLOGIC/ LYMPHATIC**
easy bruising
excessive bruising
history of blood transfusion
swollen lymph nodes

**PSYCHIATRIC**
anxiety
depression
feeling stress
personality change
poor concentration
sleep disturbance
suicidal thoughts

**ENDOCRINE**
enlarging hands/feet
hair loss
heat/cold intolerance
thirst - excessive
hunger - excessive
sweating - excessive

**Circle if your blood relatives have or have had any of the following:**

Arthritis
Asthma
Cancer
Chemical Dependency
Diabetes
Fibromyalgia
Heart Disease
High Blood Pressure
Kidney Disease
Liver Disease
Strokes
Suicide
Systemic Lupus
Thyroid Disease
Other: _____

| Relation | Age | State of Health | Age at Death | Cause of Death |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brothers | | | | |
| Sisters | | | | |

**Have you ever taken or been given:**

| | | | When? Any Problems? |
|---|---|---|---|
| Anticoagulants (blood thinners - Coumadin, Heparin) | Yes | No | |
| Cortisone or Steroids | Yes | No | |
| Local anesthetic (given by a doctor or dentist) | Yes | No | |
| Aspirin | Yes | No | |

**Past Medical History (Circle conditions you have or have had in the past)**

AIDS
Alcoholism
Anemia
Arthritis
Asthma
Benign Prostatic Hypertrophy
Bleeding Disorders
Carotid Artery Stenosis
Cerebrovascular Accident
Chemical Dependency
Cholelisthiasis
Colon Cancer
Complex Regional Pain Syndrome
Congestive Heart Failure
COPD
Coronary Artery Disease
Diabetes Type 2
Fibromyalgia
Fractures
GERD
Glaucoma
Gout
Headaches, Migraines
Headaches, Tension
High Cholesterol
Hyperlipedemia
Iron Deficiency Anemia
Kidney Disease
Liver Disease
Lung Cancer
Multiple Sclerosis
Myocardial Infarction
Obesity
Osteoarthritis
Osteoperosis
Peptic Ulcer Disease
Prostate Cancer
Psychiatric Care
Seizures
Shingles
Skin Cancer
Suicide Attempt
Testicular Cancer
Thyroid Disease
Vascular Disease

Other:

_____
_____
_____

**Please list any serious illness or hospitalizations you have had in the past.**

_____ _____
_____ _____
_____ _____

**PAST SURGICAL HISTORY**

**Please list all surgeries you have had, approximate dates, and surgeon's name.**

| Surgery | Date | Surgeon |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**SOCIAL HISTORY**

How may hours do you sleep at night? _____

Do you smoke? ☐ No ☐ Yes _____ packs _____ years

How much coffee or caffeinated beverages (tea, cola, etc.) do you drink daily? _____

Specify: _____

How much beer or alcoholic beverages do you drink daily? _____

Specify: _____

What is your occupation? _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Exercise: Type: _____ Frequency: _____