**UNIFOUR PAIN TREATMENT CENTER**
**PATIENT DATA FORM**

Please complete this form prior to your appointment. Please be as accurate as possible. The information is confidential and will be available to your health care team and their staff only.

**PLEASE BRING THIS FORM WITH YOU ON YOUR NEXT VISIT.**

Patient Information:

Full Name: _____ Date of Birth: _____

Address: _____ Home Phone: ( ) _____

_____ Work Phone: ( ) _____

May we contact you at work? Yes ( ) No ( )

Email (optional): _____ Cell: ( ) _____

Social Security Number: _____ Sex: Male ( ) Female ( ) **Age:** _____

Contact person in case of emergency: Name: _____

Home Phone: _____

Cell / Work Phone: _____

Spouse's Social Security Number: _____

Spouse's Employer: _____ Spouse's Date of Birth: _____

Approximate distance from your house to our office: _____ miles

How long is your expected travel time to our office? _____

Name, address, and phone of your pharmacy: _____

_____

Insurance Information: ***Please Bring All Insurance Cards With You***

Insurance Company: _____

Certificate No.: _____ Group No.: _____

Insured Name: _____

Relationship to you: ( ) self ( ) spouse ( ) other _____

Additional Insurance: _____

Certificate No.: _____ Group No.: _____

Insured Name: _____

Relationship to you: ( ) self ( ) spouse ( ) other _____

RN Initials: _____

«MedicalRecordNumber» «Room»-«Bed»
«PatientName»
«AttendingDoctorName»
«Age» «Gender» «HospitalService» «FinClass»
«PatientNumber» «BirthDate»
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Prior Treatment:

Please list the **full name, address, phone number, and practice name** of your:

| Family Physician or Internist | Referring Doctor (if different) |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Below are listed different medical specialties. Indicate if you have seen any of these specialists for your pain condition. List doctor's **full name, location, and name of practice**. (please fill in names that apply)

| Specialty | Doctor's Name | Specialty | Doctor's Name |
|---|---|---|---|
| Allergist | _____ | Orthopedic Surgeon (bones) | _____ |
| Anesthesiologist | _____ | Pain Specialist | _____ |
| Cardiologist (heart) | _____ | Pediatrician (children) | _____ |
| Chiropractor | _____ | Plastic Surgeon | _____ |
| Dermatologist (skin) | _____ | Psychiatrist/Psychologist | _____ |
| Dentist/Oral Surgeon | _____ | Physiatrist (rehab) | _____ |
| Ear, Nose, & Throat | _____ | Radiation Oncologist | _____ |
| Endocrinologist | _____ | Rheumatologist (arthritis) | _____ |
| General/Family Practice | _____ | | |
| Internal Medicine (internist) | _____ | Physical Therapy Therapist: | _____ |
| Neurologist (nervous system) | _____ | Facility: | _____ |
| Neurosurgeon | _____ | Acupuncturist | _____ |
| Obstetrician/Gynecologist | _____ | Herbalist | _____ |
| Oncologist/Hematologist (cancer/blood) | _____ | Other | _____ |
| | | *No. of emergency room visits re: pain within the last year?* | _____ |
| Ophthalmologist (eyes) | _____ | | |

Have you ever been to a **pain clinic** before? If so, please give name, location, and type of therapy performed:

_____

_____

**HISTORY OF PRESENT ILLNESS:**

When did your pain begin? _____

What part(s) of your body hurts? _____

_____

If multiple areas of pain, which is the worst area? _____

RN Initials: _____

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Please describe what happened or exactly how this pain began (if related to an accident, give date & details):

_____

_____

Do you know or have been told what is causing your pain? _____

_____

On the following scale, rate your pain right now: *(circle one)*

*PAIN SCALE*: 0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

On the following scale, rate your average daily pain: *(circle one)*

*PAIN SCALE*: 0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

On the following scale, rate you pain at its worst: *(circle one)*

*PAIN SCALE*: 0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

Describe your pain sensations: *(check all that apply)*

| | | | | | |
|---|---|---|---|---|---|
| Dull ache | ___ | Twisting | ___ | Superficial (on surface) | ___ |
| Burning | ___ | Throbbing | ___ | Deep | ___ |
| Continuous | ___ | Grinding | ___ | Stinging | ___ |
| Electric shock | ___ | Pressure | ___ | Other: _____ | |
| Sharp/stabbing | ___ | Tearing | ___ | _____ | |

What makes your pain BETTER: *(check all that apply)*

| | | | | | |
|---|---|---|---|---|---|
| Sitting | ___ | Applying heat | ___ | Medications | ___ |
| Standing | ___ | Applying cold | ___ | Nerve blocks | ___ |
| Moving around | ___ | Massage | ___ | Stretching | ___ |
| Lying down | ___ | Exercise | ___ | Physical Therapy | ___ |
| | | | | Other: _____ | |

What makes your pain WORSE: *(check all that apply)*

| | | | | | |
|---|---|---|---|---|---|
| Sitting | ___ | Applying heat | ___ | Medications | ___ |
| Standing | ___ | Lifting | ___ | Nerve blocks | ___ |
| Moving around | ___ | Massage | ___ | Physical therapy | ___ |
| Lying down | ___ | Exercise, bending | ___ | Other: _____ | |
| Driving | ___ | Damp weather | ___ | _____ | |

**Circle** the treatments you have tried for pain: Heat Cold Medications Physical Therapy Biofeedback Acupuncture Chiropractor Injections TENS Surgery Spinal Cord Stimulator Intrathecal Pump
Other:_____

What treatment (including medications) has helped your pain **the most**? _____

_____

RN Initials: _____

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## PAST MEDICAL HISTORY / REVIEW OF SYSTEMS:

Please indicate if you have or have had any of the following medical conditions: (please answer all)

| **Cardiovascular:** | **YES** | | **NO** |
|---|---|---|---|
| Heart attack | _____ | When? | _____ |
| Stroke/TIA | _____ | When? | _____ |
| High blood pressure | _____ | | _____ |
| Date of last EKG: | _____ | | _____ |
| Where performed: | _____ | | |
| | _____ | | |
| Chest pain/angina | _____ | | _____ |
| Irregular heart beat | _____ | | _____ |
| **Gastrointestinal:** | | | |
| Ulcers/gastritis | _____ | | _____ |
| Frequent constipation | _____ | | _____ |
| Frequent diarrhea | _____ | | _____ |
| Freq. heartburn/indigestion | _____ | | _____ |
| Nausea | _____ | | _____ |
| Incontinence of stool | _____ | | _____ |
| **Hematologic:** | | | |
| Immune diseases | _____ | | _____ |
| Hemophilia | _____ | | _____ |
| Taking blood thinner | _____ | Name: | _____ |
| Frequent nose bleeds | _____ | | _____ |
| Bleeding problems | _____ | Specify: | _____ |
| **Genitourinary:** | | | |
| Kidney function problems | _____ | | _____ |
| Kidney stones | _____ | | _____ |
| Problems urinating | _____ | | _____ |
| Specify type of problem: _____ | | | |
| Sexual function problems | _____ | | _____ |
| **Musculoskeletal:** | | | |
| Fibromyalgia | _____ | | _____ |
| Arthritis | _____ | | _____ |
| Chronic Fatigue Syndrome | _____ | | _____ |
| Skin color/temp changes | _____ | | _____ |
| **Constitutional:** | | | |
| Frequent fevers | _____ | | _____ |
| Recent weight loss | _____ | lbs. | _____ |
| Recent weight gain | _____ | lbs. | _____ |
| Frequent night sweats | _____ | | _____ |

| **Respiratory:** | **YES** | | **NO** | |
|---|---|---|---|---|
| Asthma | _____ | | _____ | |
| Smoking now | _____ | | _____ | |
| # packs per day | _____ | | | |
| If quit, when? _____ | # years smoked ____ | | | |
| Lung disease | _____ | Specify: _____ | | |
| Sleep apnea | _____ | | _____ | |
| Snoring | _____ | | _____ | CPAP? ____ |
| Chronic cough | _____ | | _____ | |
| Shortness of breath | _____ | | _____ | |
| **Neurological:** | | | | |
| Seizures/epilepsy | _____ | | _____ | |
| Numbness | _____ | Where? | _____ | |
| Weakness | _____ | Where? | _____ | |
| Headaches | _____ | How often? | _____ | |
| Dizziness | _____ | How often? | _____ | |
| Restless legs | _____ | | _____ | |
| **Endocrine:** | | | | |
| Thyroid problems | _____ | | _____ | |
| Diabetes | _____ | | _____ | |
| On insulin? | _____ | | _____ | |
| Liver problems | _____ | Specify: | _____ | |
| Hepatitis | _____ | Type? | _____ | |
| **Emotional/Psychiatric:** | | | | |
| Depression | _____ | | _____ | |
| Anxiety/panic | _____ | | _____ | |
| Violent behavior | _____ | | _____ | |
| Irritability | _____ | | _____ | |
| Suicidal thoughts | _____ | | _____ | |
| **Eyes, Ears, Nose, Throat:** | | | | |
| Visual problems | _____ | | _____ | |
| Hearing loss | _____ | | _____ | |
| Bleeding gums | _____ | | _____ | |
| Problems swallowing | _____ | | _____ | |

*List major diseases / medical illnesses:*

_____

_____

_____

Possibility you are pregnant? **( ) yes ( ) no**

RN Initials: _____

**Your Height:** _____

**Weight:** _____

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On average, how many hours per night do you sleep? _____ hrs.

If you awaken frequently, what is the cause? _____

Have you ever been diagnosed with cancer? ( ) yes ( ) no
If yes, type of cancer: _____

Date of last cancer follow-up: _____ Doctor treating you for cancer: _____

How much alcohol (beer, wine, liquor) do you consume per week? _____ /week

Do you use any street drugs? ( ) yes ( ) no If yes, specify:_____

Have you ever used prescription drugs for non-medical reasons? ( ) yes ( ) no

Have you ever had a problem with drugs (prescription or non-prescription) or alcohol in the past? ( ) yes ( ) no
If yes, specify: _____

Have you ever been arrested/convicted due to charges related to drugs (prescription or non-prescription) or alcohol? ( ) yes ( ) no
If yes, specify:_____

**MEDICATIONS:**
Please list all your current medications below (include over-the-counter drugs):

| **Name of Drug & Strength** | **Number Taken per Day** | **Prescribing Doctor** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Have you been on any of the following medications for your current pain problem?
( ) narcotics ( ) tranquilizers ( ) muscle relaxants ( ) anti-inflammatories ( ) steroids

List all things (including medications & tape) that you are **ALLERGIC** or have bad reactions to:

_____ _____
_____ _____

Have you ever had a reaction to intravenous **contrast (dye)** or **iodine**? **( ) yes ( ) no**

Are you allergic to any shellfish? **( ) yes ( ) no**

RN Initials: _____

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*FRM-HP*

**SURGICAL HISTORY:**

Have you ever had surgery to relieve your current pain condition? ( ) yes ( ) no

If yes, indicate surgeon name, location procedure performed at (i.e. hospital name), date, and type of surgery:

_____

_____

If no, have you been told you may need surgery for your current pain problem? ( ) yes ( ) no

List all major surgeries which you have had in the past:

| Name of Surgery | Where & Date Performed | Name of Surgeon |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Have you ever had a problem with anesthesia? ( ) yes ( ) no
If yes, please specify: _____

**SOCIAL HISTORY:**

Current Marital Status: Single ( ) Married ( ) Widowed ( ) Divorced ( )

Number of children _____ Ages of children _____ Children living with you _____

Highest level of education completed:
( ) grade school ( ) high school ( ) college/technical ( ) graduate school

Is there pending litigation related to your pain or a previous accident? ( ) yes ( ) no
If yes, your attorney's name, address, and phone: _____

_____

Goals:

Please indicate the types of things you would like to be doing, but cannot because of pain:

_____

_____

_____

Of the things listed above, which one is the most important to you?

_____

Do you believe that 100% pain relief is possible in your condition?
( ) yes ( ) no ( ) don't know

RN Initials: _____

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Employment Information:

**A.** If you are currently **EMPLOYED**, please answer the following:
(if not, skip to section B)

Employer Name and Address: _____

_____

I am employed: ( ) full-time ( ) part-time Average hours worked per week _____

How long have you been with your current employer? _____

Are you currently on Workmen's Compensation? ( ) yes ( ) no

Do you like your job? ( ) All the time ( ) Most of the time ( ) Some of the time
( ) Rarely or not at all

Are your duties at work restricted by your employer currently (e.g. light duty)? ( ) yes ( ) no

Briefly describe what you do at work; include time standing, sitting, lifting and weight of items lifted if applicable:

_____

_____

_____

**B.** If you are currently **NOT EMPLOYED**, please answer the following:

Have you ever been employed? ( ) yes ( ) no If no, skip to next section.

Last Employer Name and Address: _____

_____

Please state whether ( ) unemployed ( ) disabled ( ) retired How long? _____

If disabled, state reason(s) and physician who authorized disability:

_____

_____

Did you like your job? ( ) All the time ( ) Most of the time ( ) Some of the time
( ) Rarely or not at all

Briefly describe what you did at work, include time standing, sitting, lifting and weight of items lifted if applicable:

_____

_____

_____

RN Initials: _____

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Have you stopped working because of your current pain condition? ( ) yes ( ) no

If yes, have you attempted to return to work? ( ) yes ( ) no
If yes, ____ full-time or ____ part-time.

Do you want to return to work? ( ) yes ( ) no

**Sexual history:**

Are you sexually active? Y N

Do protect yourself from sexually transmitted diseases and HIV (e.g use of condoms)? Y N

Have you or do you currently have a sexually transmitted disease (e.g. herpes, chlamydia, gonorrhea, etc) Y N

If so, please specify type and year: _____

Do you have a history of sexual abuse? ( ) ( ) no When? _____

**Military history:**

Have you ever served in the armed forces? Y N

If so, branch, years of service, location: _____

Do you have any pain and/or psychiatric conditions as a result of military service? Y N

If so, please specify what those are: _____

**FAMILY HISTORY:**

Does any member of your immediate family have a problem with drugs or alcohol?
( ) yes ( ) no If yes, please specify: _____
_____
_____

Do any members of your immediate family have a chronic pain condition?
( ) yes ( ) no If yes, please specify: _____
_____
_____

Does your immediate family have a history of hereditary diseases or other major illness?
( ) yes ( ) no If yes, please list: _____
_____
_____

RN Initials: _____
«MedicalRecordNumber» «Room»-«Bed»
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**DIAGNOSTIC STUDIES:**

Indicate which of the following studies/tests you have had to work-up your **current pain problem**:

| Type of Study (check all that apply) | | Where Performed | Approximate Date |
|---|---|---|---|
| MRI | ____ | _____ | _____ |
| CT scan | ____ | _____ | _____ |
| Myelogram | ____ | _____ | _____ |
| EMG/nerve study | ____ | _____ | _____ |
| Plain x-rays | ____ | _____ | _____ |
| Bone scan | ____ | _____ | _____ |
| Ultrasound | ____ | _____ | _____ |
| Sleep study | ____ | _____ | _____ |
| Blood flow study | ____ | _____ | _____ |
| Stress test/treadmill | ____ | _____ | _____ |
| Cardiac cath | ____ | _____ | _____ |
| Nerve block/steroid inj | ____ | _____ | _____ |
| Other: | ____ | _____ | _____ |

RN Initials: _____

**PLEASE FILL OUT PAIN DIAGRAM AND MEDICATION HISTORY FORM ATTACHED TO THIS PACKET**

I give permission to discuss my medications, medical condition, and/or billing issues with (spouse, significant other, family, friends, etc.):

_____

By signing below, I acknowledge that the above information is true and accurate to the best of my knowledge.

Your Signature: _____ Date: _____ Time: _____

RN Signature: _____ Date: _____ Time: _____

Physician Signature: _____ Date: _____ Time: _____

«MedicalRecordNumber» «Room»-«Bed»
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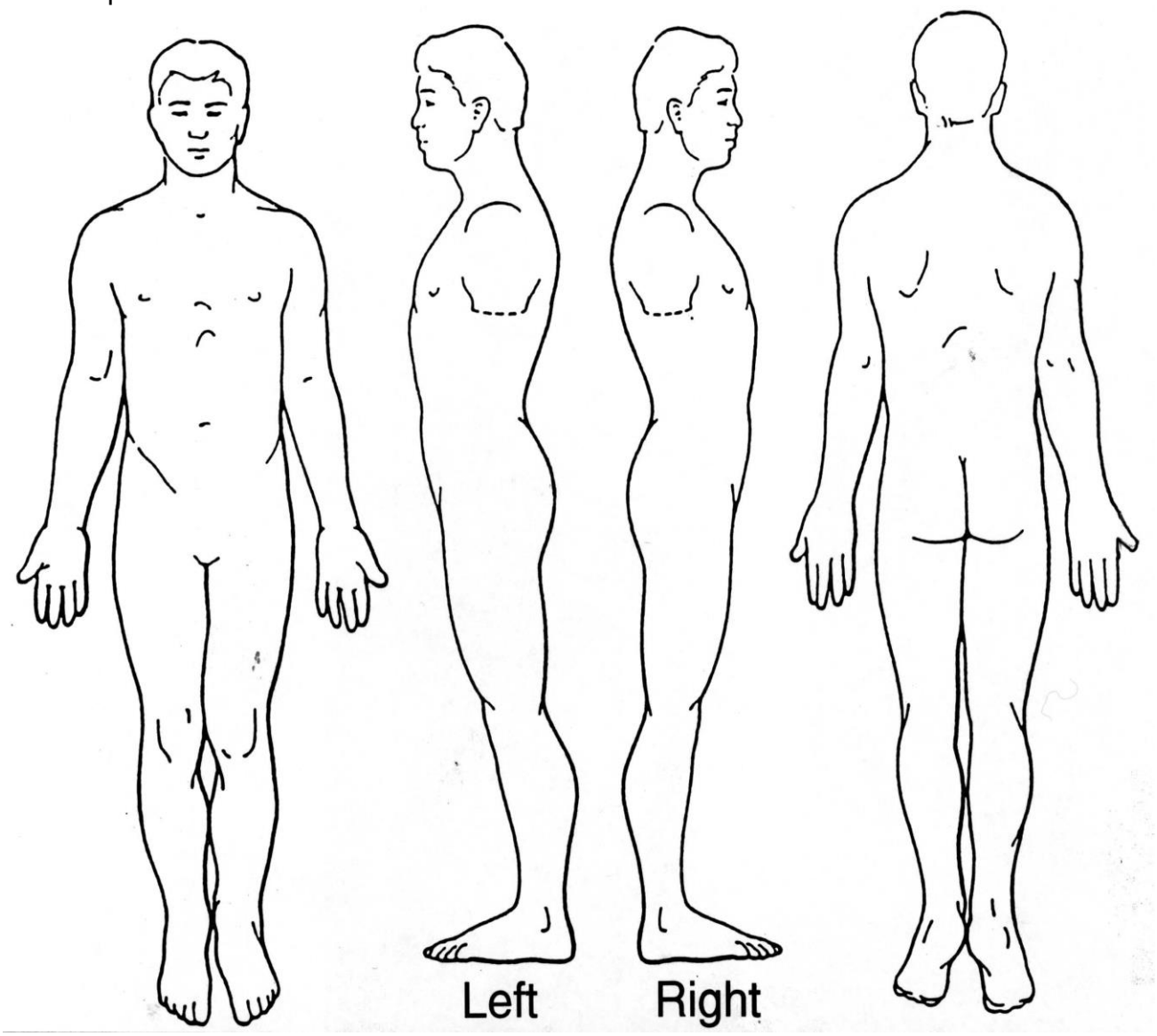
Mark on the drawing the exact spot where your pain is with a solid black dot. If the pain starts at that spot and radiates elsewhere (travels to another part of your body), draw a line from the spot where it starts to where it ends. If it is a whole area that hurts, shade in that area with a pencil.

Next to the places on drawing where you showed the pain, put an "E" if the pain is external (on the outside surface). If the pain is internal (inside the body) mark it with and "I". If the pain is both internal and external, mark "EI".
Mark also "C" for Constant, "O" for Often, or "S" for Seldom depending on how much of the time you experience the pain.

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**Frye Regional Medical Center**
**UNIFOUR PAIN TREATMENT CENTER**
**PATIENT DATA FORM**

**FMC-98 4/15 HP**

*FRM-HP*

Please underline each medication you have used in the **past.** Please **circle** each medication you are **now** using.

**ANALGESICS**

Actiq
Anacin
Aspirin
Avinza
BC Powder
Bufferin
Buprenex/Buprenorphine
Butrans Patch
Butalbital
Codeine
Darvocet
Darvon
Demerol
Dilaudid/Hydromorphone
Duragesic Patch
Embeda
Equagesic
Esgic
Exalgo
Excedrin
Fioricet
Fiorinal
Goody's Powder
Hydrocodone
Hysingla
Kadian
Lidoderm Patch
Lorect/Lortab
Methadone
Morphine
MS Contin
Norco
Nubain
Opana IR
Opana ER
Oxycontin
Oxy IR
Percocet
Percodan
Propoxyphene
Roxicet/Roxicodone
Ryzolt
Sedapap
Stadol Injection
Stadol Nasal Spray
Suboxone
Talwin
Tylenol/Acetaminophen
Tylenol #3 or #4
Tylox
Ultram/Ultracet
Vicodin
Vicoprofen
Zydone

**ANTI-MIGRAINE MEDICATIONS**

Amerge
Axert
Bellergal
DHE-45 injection
DHE Capsule
Duradrin
Ergomar
Ergotrate
Frova
Imitrex Injection
Imitrex Nasal Spray
Imitrex Tablet
Lidocaine
Maxalt
Midrin
Relpax
Sansert
Zomig

**ANTI-INFLAMMATIORIES**

Advil/Ibuprofen
Aleve/Naproxen
Anaprox
Ansaid
Arthrotec
Aspirin
Bextra
Cataflam
Celebrex
Daypro
Diclofenac
Dolobid
Feldene
Indocin
Ketoprofen
Lodine
Meclomen
Mobic
Motrin
Nalfon
Naprosyn
Nuprin
Pensaid
Relafen
Toradol
Trilisate
Voltaren
Voltaren Gel

**MUSCLE RELAXANTS**

Baclofen
Flexeril
Lioresal
Norgesic
Parafon Forte
Robaxin
Skelaxin
Soma
Zanaflex

**ANTI-CONVULSANTS**

Depakote
Dilantin
Gabitril
Gralise
Keppra
Klonpin
Lamictal
Lyrica
Neurontin/Gabapentin
Phenobarbital
Tegretol
Topamax
Trileptal
Zonegran

**STEROIDS**

Decadron
Dexamethasone
Hydrocortisone
Medrol
Prednisone

**SLEEPING PILLS/ TRANQUILIZERS**

Ambien
Ativan
Benadryl
BuSpar
Dalmane
Halcion
Librax
Librium
Lorazepam
Lunesta
Melatonex
Melatonin
Restoril
Rozerem
Seconal
Seroquel
Sonata
Thorazine
Tranxene
Trilafon
Tylenol PM
Valium
Xanax
Zyprexa

**ANTI-DEPRESSANTS**

Abilify
Anafranil
Amitriptyline
Celexa
Cymbalta
Desipramine
Desyrel
Doxepin
Effexor
Elavil
Geodon
Imipramine
Lexapro
Lithium
Luvox
Nardil
Nortriptyline
Pamelor
Paxil
Pristiq
Prozac
Remeron
Savella
Serzone
Sinequan
Tofranil
Trazodone
Vivactil
Wellbutrin
Zoloft

**HERBAl:**
(please list)

«MedicalRecordNumber» «Room»-«Bed»
«PatientName»
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