Pain Institute of Long Island

Patient Name:__________________________________ Date of Birth: ___________________

Reason for Visit: _________________________ Referring Provider:____________________

Primary Care Provider:_____________________

Allergies:

☐ **No Known Allergies** ☐ **Food Allergies ____________________________________**

☐**Drug Allergies___________________________________**

Medical History: **HEIGHT:__________________WEIGHT:_________________________**

□A-Fib	□Dementia	□Myocardial Infarction
□Anemia	□Depression	□Nerve/ Muscle Disease
□Anxiety	□ Diabetes	□Osteoporosis
□Arthritis	□Emphysema	□Pancreatitis
□ Asthma	□GERD	□Rheumatic Fever
□Blood Transfusion	□Glaucoma	□Seizures
□ Cancer	□Heart Murmur	□Sickle Cell Disease
*Type:*_______________	□Hemorrhoids	□Spinal Stenosis
□Cataracts	□HIV/AIDS	□Stroke
□ CHF	□Hypertension	□Substance Abuse
□Clotting Disorder	□Kidney Disease	□Thyroid Disease
□COPD	□Meningitis	□Tuberculosis
□Coronary Artery Disease	□Bowel/Bladder Changes	□Ulcers

Other: ____

____

Surgical History: **Please list any previous surgeries you have had.** □ **No Past Surgeries**

Date: ________________ Surgery: ________________________Surgeon:________________

Date: ________________ Surgery: ________________________Surgeon:________________

Date: ________________ Surgery: ________________________Surgeon:________________

Family History: **Mother:** ☐**ALIVE** ☐ **DECEASED _______________________________**

Father: ☐**ALIVE** ☐ **DECEASED _______________________________**

Siblings: □**Sister:____**

□**Brother____**

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Social History:

☐ **Married** ☐ **Single** ☐ **Divorced**

Smoking History: ☐ **Never Smoker** ☐ **Current Smoker** ☐ **Former Smoker-Date quit :_____**

Alcohol Use: ☐ **Never** ☐ **Occasionally** ☐ **Daily ~ Number of Drinks:____________**

History of Alcohol/ Drug Abuse by Family Member ☐ **None**

Other:____

Personal History of Recreational Drug Use (Past/ Current)

Cocaine_____________ Marijuana _____________ Heroin ________________

Oher ___________________

Psychiatric History ☐ **None** ☐ **Depression** ☐ **Anxiety** ☐ **Other ______________________**

Pharmacy: Name:______________________ Location:_______________________

Medication: ☐ **Not taking any medication**

Are you currently taking blood thinners?

☐ **No** ☐ **Yes**

☐ **Coumadin** ☐ **Xarelto** ☐ **Plavix** ☐ **Eliquis** ☐ **Other____________________**

Medication	Dose	Route	Frequency
______________	______	________	____________
______________	______	________	____________
______________	______	________	____________

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Pain Assesment:

Pain Level Today: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Pain Location: ☐Back ☐Neck ☐Hip ☐Knee ☐Abdomen ☐Ankle ☐Arm

☐Buttocks ☐Finger ☐Foot ☐Pelvis ☐ Shoulder ☐Leg

Other ______________________________________

Side: ☐Right ☐Left ☐Bilateral ☐Upper ☐Lower

Pain Frequency: ☐Continuous ☐Rarely ☐Intermittent

☐Constant/Continuous ☐Other ______________________

Aggravating Factors: ☐Bending ☐Exercise ☐Kneeling ☐Lifting ☐Sitting

☐Standing ☐Walking ☐Transfers ☐Stairs ☐Weather ☐Stress

☐Pain worse in morning ☐ Worse afternoon ☐Worse at Night

Type of Pain: ☐Sharp ☐Dull/Aching ☐Radiating ☐ Tingling ☐ Burning ☐Throbbing ☐Numbness

Other Description: ____

____

____

Have you recently had: ☐ Physical Therapy ☐Acupuncture ☐Chiropractic Care

Interventional Pain Procedures :

☐Epidural Injection ☐Medial Branch Block/Facet Joint ☐RFA ☐Trigger Points

☐Other ____

____

Name of previous Pain Management Physicians you have seen:

____

____

____

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Mark the following symptoms that you currently suffer from:

Constitutional:

☐ Chills ☐Difficulty sleeping ☐ Easy bruising
☐ Night Sweats ☐Fatigue ☐ Fevers
☐ Insomnia ☐ Low sex drive ☐ Tremors
☐Weakness
☐ Unexplained Weight Gain ☐ Unexplained Weight Loss

Eyes: ☐ Recent Visual changes

Ears/Nose/Throat/Neck:

☐ Dental Problems ☐ Earaches ☐ Hearing Problems
☐ Nosebleeds ☐ Sinus problems

Cardiovascular:

☐ Chest Pain ☐ Bleeding Disorder ☐ Blood Clots
☐ Fainting ☐ Palpitations ☐ Swelling in feet
☐ Shortness of breath during sleep

Respiratory:

☐ Cough ☐ Wheezing ☐ Shortness of breath

Gastrointestinal:

☐ Constipation ☐ Acid Reflux ☐Abdominal Cramps
☐ Diarrhea ☐ Nausea/Vomiting ☐ Hernia

Musculoskeletal:

☐ Back Pain ☐ Joint Pains ☐ Joint Stiffness
☐ Joint Swelling ☐ muscle spasms ☐ Neck Pain

Genitourinary/Nephrology:

☐ Flank Pain ☐ Blood in Urine ☐ Painful Urination
☐ Decreased Urine Flow/Frequency/Volume

Neurological:

☐ Dizziness ☐ Headaches ☐ Tremors
☐ Numbness/Tingling

Psychiatric:

☐ Depressed Mood ☐ Feeling Anxious ☐ Stress Problems
☐ Suicidal Thoughts ☐ Suicidal Planning ☐ Thoughts of Harming Others

☐ **All other review of systems negative**

Practitioner Signature: ______________________________