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** ________________________________

Do you have allergy to medical dye or contrast? ☐ **No** ☐ **Yes**

Do you have a latex or shellfish allergy? ☐ **No** ☐ **Yes**

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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<u>Social History</u>: ☐ Married ☐ Single ☐ Divorced

<u>Smoking History</u>: ☐ Never Smoker ☐ Current Smoker

☐Former Smoker-Date quit: _____

<u>Alcohol Use</u>: ☐ Never ☐ Occasionally ☐ Daily ~ Number of Drinks: ____________

☐History of Alcohol/ Drug Abuse by Family Member ☐ None ☐ If Yes, please explain

____

<u>Personal History of Recreational Drug Use (Past/ Current)</u>

Cocaine_______________ **Marijuana** _______________ **Heroin** _________________

Oher _____________________

Psychiatric History ☐ None ☐Depression ☐Anxiety ☐Other _______________________

Pharmacy: Name: __________________________ **Location:** ___________________________

<u>Medication</u>: ☐ 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 Assessment

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/Constant ☐ Rarely ☐ Intermittent- comes and goes

☐ 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 ☐Shooting

Other Description: ____

Have you had any recent changes in your bowel and or bladder function? ☐ Yes ☐ No

If yes, please explain: ____

Have you recently had: ☐ Physical Therapy Date ☐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 ☐ Snoring/Sleep Apnea

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

BLOOD

☐ Prolonged bleeding ☐ Easy Bruising

☐ All other review of systems negative

Practitioner Signature: ______________________________ Date:_____________

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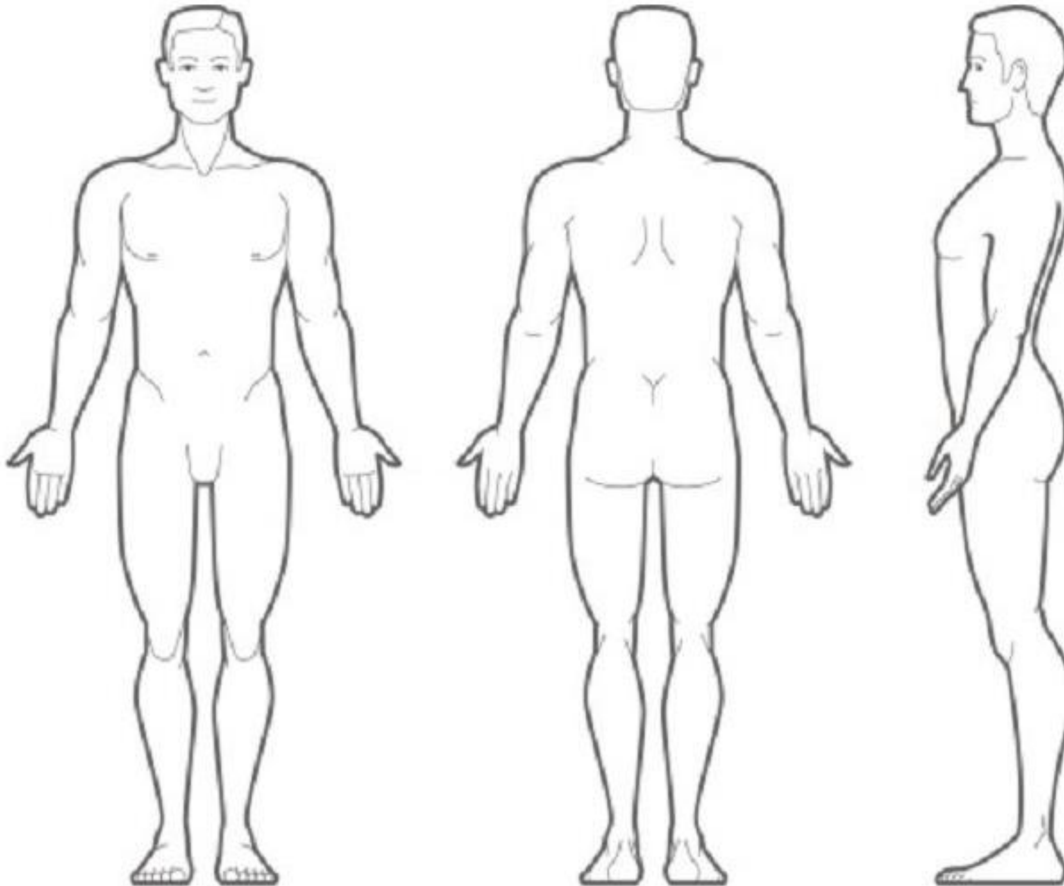
Name:_________________________________ **DOB:**_________________

Shade the areas of your pain on the images below:



How long have you had the pain? ____

How did it start? ____

____