Pain Institute of Long Island

PORT JEFFERSON STATION
96 Terryville Road
Port Jefferson Station, NY 11776

PORT JEFFERSON
70 North Country Road, Suite 203
Port Jefferson, NY 11777

ROCKVILLE CENTRE
77 North Centre Avenue, Suite 202
Rockville Centre, NY 11570

RIVERHEAD
300 Old Country Road, Suite 1
Riverhead, NY 11901

WOODBURY
205 Froehlich Farm Blvd
Woodbury, NY 11797

PLAINVIEW
146A Manetto Hill Road, Suite 100
Plainview, NY 11803

Patient Name: _____ Date of Birth: _____

Reason for Visit: _____ Referring Provider: _____
Primary Care Provider: _____

Allergies:

☐ No Known Allergies ☐ Food Allergies _____ ☐ Drug Allergies_____

Do you have an 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: _____

Patient Name: _____ Date of Birth: _____

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_____

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 ☐ If Yes, please explain

_____

Personal History of Recreational Drug Use (Past/ Current)

Cocaine_____ Marijuana _____ Heroin _____ Oher _____

Psychiatric History ☐ None ☐ Depression ☐ Anxiety ☐ Other _____

Medication: ☐ Not taking any medication

Pharmacy: Name: _____ Location: _____

Are you currently taking blood thinners? ☐ No ☐ Yes

☐ Coumadin ☐ Xarelto ☐ Plavix ☐ Eliquis ☐ Other_____

Medication Dose Route Frequency

_____

_____

_____

Patient Name: _____ Date of Birth: _____

Pain Assessment

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

Pain Location:

☐ Back ☐ Neck ☐ Hip ☐ Knee ☐ Leg
☐ Abdomen ☐ Ankle ☐ Arm ☐ Buttocks ☐ Shoulder
☐ Finger ☐ Foot ☐ Pelvis 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 ☐ 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:

_____

Patient Name: _____ Date of Birth: _____

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

Patient Name: _____ Date of Birth: _____

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

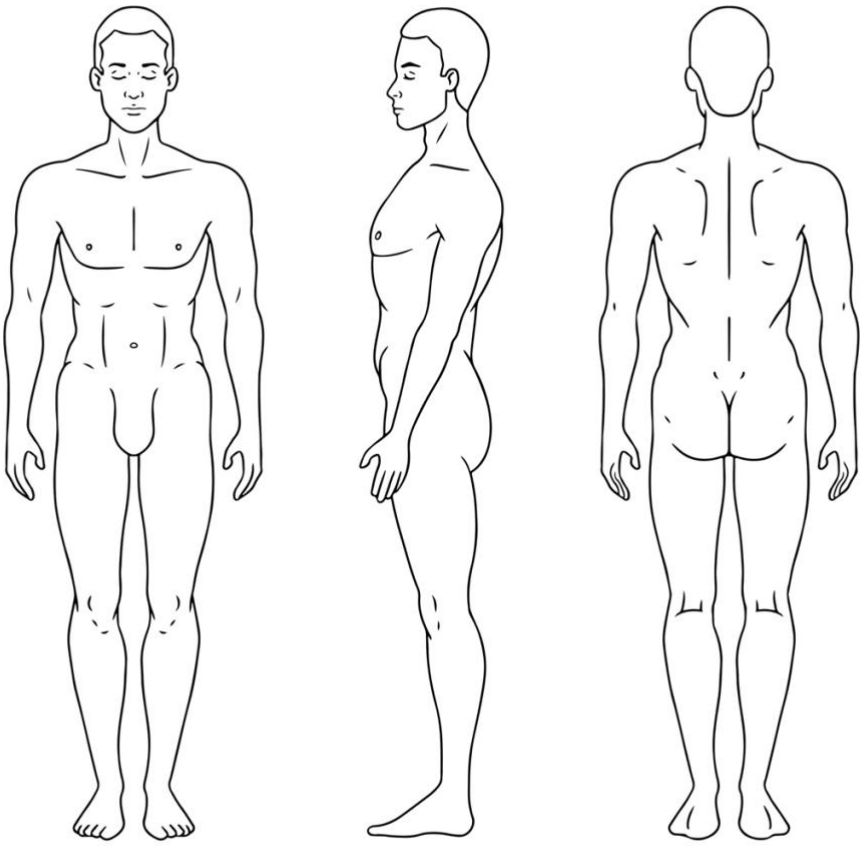
☐ All other review of systems negative

Name: _____ Date of Birth: _____

Practitioner Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

Shade the areas of your pain on the images below:



How long have you had the pain? _____

How did it start? _____