

**NEW PATIENT HISTORY**  
**PAIN PARTNERS, M.D., LLC**

**NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

Do you smoke?  Yes  No  
If yes: How many per day? \_\_\_\_\_

Do you chew tobacco?  Yes  No  
How often? \_\_\_\_\_

Do you drink alcohol?  Yes  No  
How much? \_\_\_\_\_  
How often? \_\_\_\_\_

Do you have a history or have you ever been treated for substance abuse?  Yes  No  
Substance: \_\_\_\_\_  
When? \_\_\_\_\_  
Where? \_\_\_\_\_

Do you have an Implanted pain pump or Simulator?  
 Yes  No  
When? \_\_\_\_\_  
Where? \_\_\_\_\_

**MEDICATIONS:** (include supplements/vitamins)

<b>Name:</b>	<b>Dose:</b>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

<b>Allergies:</b>	<b>Reactions:</b>
_____	_____
_____	_____
_____	_____
_____	_____

Are you taking a blood thinner? (Coumadin, Plavix, TICLID, ASA or NSAIDS)  Yes  No

**SURGERIES:** (Please list all surgeries you have had)

<b>Surgery:</b>	<b>Date:</b>	<b>Location:</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**STUDIES:**

What tests and studies have been done? (For example: MRI, CT-Scan, X-Rays, EMG, Injections)

<b>Test:</b>	<b>Date:</b>	<b>Facility:</b>	<b>Body Location:</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**FAMILY HISTORY:** (Please list your family medical history.)

<b>Condition:</b>	<b>Family Member:</b>
_____	_____
_____	_____
_____	_____
_____	_____

1. Briefly state the nature of your problem: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. How long have you had this problem?  
\_\_\_\_\_

3. Is this a work related injury?  YES  NO      Date of injury \_\_\_\_\_

4. Automobile accident?  YES  NO      Date of accident \_\_\_\_\_

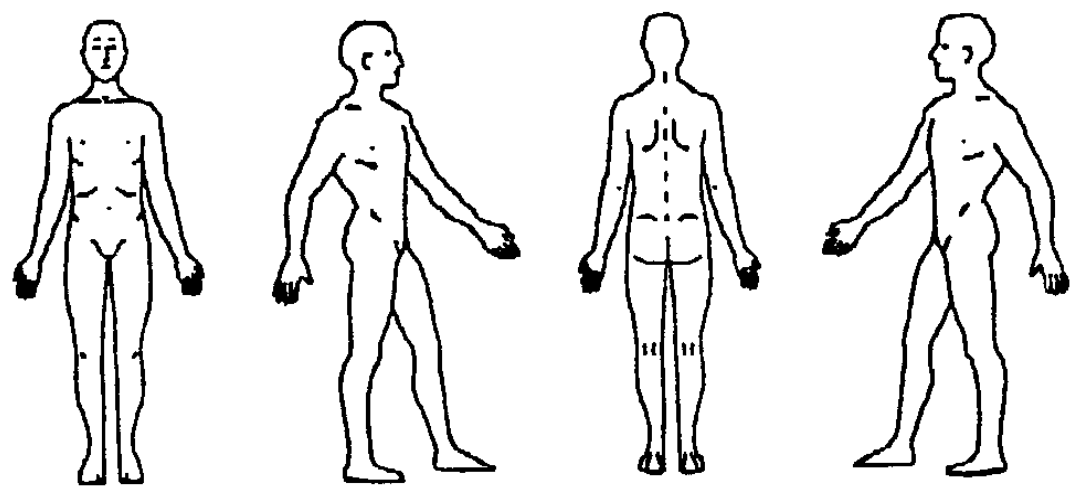
6. How would you describe your pain (circle only those words that apply)?

- |           |            |              |
|-----------|------------|--------------|
| Aching    | Sharp      | Numbing      |
| Throbbing | Tender     | Tingling     |
| Shooting  | Burning    | Continuous   |
| Stabbing  | Exhausting | Intermittent |

7. On a scale of **0 to 10**, what is your usual level of pain?  
(0 being pain free and 10 being the worst pain imaginable, please circle number)



8. On the diagram below, shade the area(s) on the body where you feel pain. "X" the areas that hurt the most.



REVIEW OF SYSTEMS: (Check all current and past problems.)

General:

- Recent Fever
- Recent Weight Loss
- Fatigue
- History of Cancer

Eyes:

- Wear Glasses/Contacts
- Date of last exam: \_\_\_\_\_
- Eye Infection
- Injuries
- Cataracts
- Glaucoma

Ear, Nose, Throat and Mouth:

- Wear Hearing Aids
- Hearing Loss
- Ear Pain
- Ear Infections
- Ringing in Ears:  
Right  Left  Both
- Balance Disturbance
- Nosebleeds
- Inability to Smell

Genitourinary:

- Blood in Urine
- Difficulty Starting or Stopping Stream
- Incontinence
- Kidney Problems
- Prostate Problems

Endocrine:

- Diabetes  
Type: \_\_\_\_\_
- Use Insulin
- Thyroid Disease

Skin:

- Skin Cancer  
Type: \_\_\_\_\_
- Breast Pain, Tenderness or Swelling (female)
- Breast Cancer

Skin Continued:

- Nipple Discharge (females)  
Date/Result of Last Mammogram (Females):  
\_\_\_\_\_

Cardiovascular:

- History of Heart Attack
- Chest Pain
- Heart Disease
- Date of last EKG: \_\_\_\_\_
- High Blood Pressure
- Irregular Heart Rate
- Heart Murmur
- High Cholesterol
- Swelling in Feet or Hands
- Stents  
Date: \_\_\_\_\_
- Pacemaker  
Date: \_\_\_\_\_

Gastrointestinal:

- Blood in Vomit
- Liver
- Jaundice
- Reflux/Heartburn
- Ulcers
- Colon, Liver, or Stomach,
- Prostate Cancer (males)
- Uterine or Cervical Cancer (females)

Respiratory:

- Asthma
- Emphysema (COPD)
- Bronchitis
- Pneumonia
- Lung Cancer
- TB  
Date of Last Chest X-ray: \_\_\_\_\_
- On Oxygen  
Amount: \_\_\_\_\_

Respiratory Continued:

- CPAP/BiPAP

Musculoskeletal:

- Back Pain
- Neck Pain
- Arm Pain
- Leg Pain
- Leg Weakness
- Arthritis

Neurological

- Headaches
- Seizures
- Difficulty with Speech
- Double or Blurred Vision
- Face Weakness

Psychiatric:

- Anxiety
- Depression
- ADHD
- Bipolar
- Other: \_\_\_\_\_

Blood/Lymph:

- Anemia
- Hemophilia
- Bleeding tendencies
- Persistent Swollen Glands or Lymph Nodes
- Blood Transfusion  
When: \_\_\_\_\_

- Immunologic Disorder
- HIV
- Hepatitis  
Type: \_\_\_\_\_
- BB Illness

Females only:

- Date of last menstrual period: \_\_\_\_\_
- Could you be pregnant?  
 Yes  No