PMRC

Patient Treatment/Medical History

Name:

Last: First: Middle:

Date of Birth:

Please explain your primary area of pain and date of onset?

Spreading Pain - Do you feel pain or discomfort, numbness, and/or tingling in other areas? Please describe.

Is this is a workplace related injury?

Is this pain due to trauma, accident or injury?

What seems to aggravate the pain? (standing, sitting, walking, driving, lifting etc.)

What seems to relieve the pain? (ice, heat, laying down)

Have you been seen by another Pain Specialist or received treatment for your pain?: If yes, please provide details of the other provider(s) Diagnostics i.e, labs, x-rays), treatments (ie. Medications, injections, physical therapy, chiropractic), Dates, as well as the Results of such.

Provider/Diagnostics/Treatments 1 - Who, What Where, When

Provider/Diagnostics/Treatment 2 - Who, What Where, When

Provider/Diagnostics/Treatment 3 - Who, What Where, When

Past Medical History:

No	Yes	If yes, list date of onset or diagnosis and explain:
		Heart attack
		Irregular Heartbeat
		Stroke
		High/Low Blood pressure
		Lung Problems
		Diabetes
		Stomach/Colon Condition
		HIV/Hepatitis
		Liver Disease/Cirrhosis
		Urinary Problems
		Arthritis
		Neurological Conditions
		Seizure Disorder
		Psychiatric Disorder
		Anxiety
		Depression
		Fibromyalgia
		Cancer
		Motor Vehicle Accident
		Accident/Fall/Injury
		Other:

Surgical History: List ALL surgeries you have had.

Year Surgery Details

Allergy History: medication, food environment and type of reaction with each

Allergy to: Reaction:

Social History:

Tobacco Use: Smoke Qty Years

Chew Qty Years

Alcohol Use: No Consumption Social Drinker (once week)

#Beers /day # Wine glasses/day # hard liquor/day

Illicit Drug Use:

Have you ever abused narcotics or used illicit drugs (illegal)including Marijuana?

Have you ever been arrested for selling or distributing narcotics?

Have you ever received in-patient or out-patient treatment for substance abuse?

Work History:

Do you currently work? Are you retired?

Recent loss of job? Unemployed?

Are you on disability? If yes, date and reason granted

Family Medical History:

	Type/Location	Mother	Father	Sister	Brother
Cancer					
Cancer					
Cancer					
Heart Attack					
Congestive Heart Failure					
Hardening of the arteries					
High Blood Pressure					
Stroke					
Asthma					
COPD					
Emphysema					
Crohn's Disease					
Hepatitus					
Thyroid Disease					
Diabetes as a child					
Diabetes as an adult					
Other					
Other					
Other					

Name: **Date of Birth:**

Current Medications:

Please review all your medicine bottles and provide the information below. Include over the counter medications too.

Medication Name	mg/mcg	Dose Instructions	# Refills	Date Filled	Prescriber's Name