A.T. Carrasco, MD

Pain Management New Patient Questionnaire

Name:_____Age:_____DOB:_____/_____/_____Sex:_____

MEDICAL HISTORY: (please circle all that apply)

Hypertension	Heart Condition	Stroke	Muscular Dystrophy	Sickle Cell
Lung Problems	Thyroid (high / low)	Cancer	Multiple Sclerosis	Hepatitis
Anemia	Asthma	Arthritis	Diabetes (insulin dependent / non-insulin dependent)	

SURGERIES: (please list all surgeries and dates)

_____

_____

_____

CHRONIC/SERIES ILLNESS: (please list, i.e., arthritis, kidney disease, fibromyalgia, osteoarthritis)

_____

HAVE YOU SEEN A PHYCHOLOGIST/PSYCHIATRIST FOR YOUR PAIN? (state last visit and Dr.'s name)

_____

CURRENT MEDICATIONS: (include over the counter medications)

Name of Medication	Dosage	How much & how often

ALLERGIES: (list medication and your reaction)

_____

ANESTHESIA: (please list any reactions you have had)

_____

Patient Name:_____ **ACCT #:**_____ **Date:**_____

CHILDHOOD ILLNESSES (please circle): Chicken pox Measles Mumps Polio

IMMUNIZATIONS: Have you had a tetanus booster within the past 10 years? ☐ Yes ☐ No

FAMILY HISTORY:

Father: ☐ Living ☐ Deceased Health Problems:_____ Cause of Death:_____

Mother: ☐ Living ☐ Deceased Health Problems:_____ Cause of Death:_____

Brothers: # Living:_____ Health Problems:_____

Deceased:_____ Health Problems:_____

Sisters: # Living:_____ Health Problems:_____

Deceased:_____ Health Problems:_____

Children: # Living:_____ Health Problems:_____

Deceased:_____ Health Problems:_____

SOCIAL HISTORY:

Do you smoke or use tobacco products? ☐ Yes ☐ No

If yes, How much a day?_____ How many years?_____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much a month? Beer:_____ Wine:_____ Liquor:_____

Caffeine: How many cups of coffee, soda, or tea do you drink a day?_____

Do you use illicit substances, if so describe_____

What is your highest level of education?_____

What is your occupational title?_____

How many hours a week do you work?_____ Please list any restrictions:_____

Marital Status:_____ Length of Marriage:_____

INJECTIONS FOR PAIN: (please list any injections you have received for pain, including dates and the doctor's name)

_____

_____

_____

Patient Name:_____ **ACCT #:**_____ **Date:**_____

DIAGNOSTIC TESTING:

Type of Study	Date	Part of Body Evaluated	Ordering Physician	Place of Service
Bone Scan				
Discogram				
CT Scan				
MRI				
EMG				
X-Ray				
Blood Test				
Myelogram				

Have you attended physical therapy for your current condition: ☐ Yes ☐ No

_____times a week for _____weeks. Date last attended:_____

Please list any physicians you have seen for your current condition:

Name: **Phone:**

_____ _____

_____ _____

_____ _____

_____ _____

REVIEW OF SYSTEMS

Please indicate if you currently have any of the following

SKIN (INTEGUMENT)	YES	NO	COMMENTS
Growths			
Itching			
Lesions			
Prolonged Healing			
Color Changes in the Skin			

EYES	YES	NO	COMMENTS
Last Eye Exam			
Corrective Lenses (glasses/contacts)			
Infections			
Injuries			
Glaucoma			
Cataracts			
Visual Disturbances			
Seeing Double			
Seeing Spots			

EARS	YES	NO	COMMENTS
Pain			
Infection			
Ringing			
Dizziness			
Hearing Loss			

NOSE & THROAT	YES	NO	COMMENTS
Last Dental Exam			
Dental Prosthesis (bridge, dentures)			
Bleeding Gums			
Sore Throats			
Difficulty Swallowing			
Hoarseness			
Swelling of the Glands			
Nasal Congestion			
Nose Bleeds			
Allergies			

GASTROINTESTINAL	YES	NO	COMMENTS
Constipation			
Diarrhea			
Changes in Bowel Habits			
Dark Stools			
Blood in Stools			

REVIEW OF SYSTEMS, Cont.

GENITOURINARY	YES	NO	COMMENTS
Increased Urination			
Increased Urination at Night			
Difficulty Urinating			
Blood in Urine			
Difficulty Holding Your Urine			
Hesitancy			
Urgency			
Diminished Stream			
Frequent Urinary Tract Infections			
Kidney Stones			
Incontinence			

MALE REPRODUCTIVE	YES	NO	COMMENTS
Self Testicular Exams			
Prostate Exam/Date			
Scrotal Pain or Swelling			
Impotence			
Abnormal Discharge from Penis			
Hernia			
Sexually Transmitted Disease			

FEMALE REPRODUCTIVE	YES	NO	COMMENTS
# of Pregnancies			
# of Abortions			
# of miscarriages			
# of deliveries			
Last Menstrual Cycle			
Last Pelvic Exam/Pap Smear			
Menstrual Difficulties			
Sexually Transmitted Disease			
Post-menopausal Problems			
Largest Infant Weight			

BREASTS	YES	NO	COMMENTS
Self-breast Exam			
Mammogram (If yes, date?)			
Pain to Breasts			
Lumps to Breasts			
Discharge from Breasts			

CARDIOPULMONARY	YES	NO	COMMENTS
Chronic Cough			
Shortness of Breath			
Difficulty Breathing on Exertion			
Waking Up Short of Breath			
Night Sweats			
Difficulty Breathing Lying on Back			
Unusual Fatigue			
Chest Pain or Pressure			
Edema to the Chest			
Abnormal Heart Rate			

REVIEW OF SYSTEMS, Cont.

VASCULAR	YES	NO	COMMENTS
Inflammation of Leg Veins			
Varicose Veins			
Severe Pain to the Calf while Walking			
Peripheral Vascular Disease			

ENDOCRINE	YES	NO	COMMENTS
Fatigue			
Weakness			
Increased Urination			
Increased Thirst			
Increased Hunger			
Temperature Intolerance			

GASTROINTESTINAL	YES	NO	COMMENTS
Weight or Appetite Change			
Abdominal Pain			
Nausea			
Vomiting			
Gallbladder Disease			
Liver Disease			
Pancreatic Disease			
Hiatal Hernia			
Ulcer			
Diverticulitis			
Colitis			
Hemorrhoids			

MUSCULOSKELETAL	YES	NO	COMMENTS
Arthritis			
Neck or Back Injury			
Broken Bones			
Joint Pain			
Edema to Joints			
Redness to Joints			
Warmth to Joints			
Weakness			
Prosthesis			
Ambulation Aids			
Muscle Cramping			

NEUROPSYCH	YES	NO	COMMENTS
Headaches			
Fainting			
Dizziness			
Lightheadedness			
Head Injury			
Seizure			
Movement Disorders			
Sensory Disorders			
Memory Loss			
Numbness			
Tingling			
Difficulty Speaking			