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VALLEY PAIN MANAGEMENT
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MCMECHEN, WV 26040

Patient Medical History Questionnaire

Name:_____ Date:_____

Please complete as fully as possible. This questionnaire you are about to fill out is important to your doctor and will become part of your permeant health record. **ALL INFORMATION IS REGARDED AS CONFIDENTIAL**

Please circle answers yes or no

ILLNESS: Have you ever had:

Tuberculosis..... Yes No
Rheumatic Fever..... Yes No
Diabetes (sugar)..... Yes No
Pneumonia..... Yes No
High Blood Pressure..... Yes No
Thyroid Disease.....Yes No
Venereal Disease.....Yes No
Sinus infection.....Yes No
Gall Bladder Disease.....Yes No
Jaundice.....Yes No
Cancer.....Yes No
Nervous Breakdown.....Yes No
Hemorrhoids.....Yes No
Arthritis..... Yes No
Stomach ulcers..... Yes No
Recurrent headaches..... Yes No
Colitis..... Yes No
Asthma..... Yes No
Glaucoma..... Yes No
Anemia..... Yes No
Kidney Stones..... Yes No
Heart Trouble..... Yes No
Stroke..... Yes No
Lung Disease..... Yes No

Malaria..... Yes No
Scarlet Fever..... Yes No
HIV Positive, AIDS..... Yes No
Bladder infection..... Yes No
Tonsillitis..... Yes No
Eczema..... Yes No
Psoriasis..... Yes No
Recurrent sore throat..... Yes No
Electroshock therapy..... Yes No
Bone or joint disease.....Yes No
Kidney or bladder disease....Yes No
Unexplained weight loss.....Yes No
Convulsions (fits, epilepsy)..Yes No
Head or spinal injuries.....Yes No
Fainting spells.....Yes No
Gout..... Yes No
Heartburn..... Yes No
Shortness of breath..... Yes No
Persistent hoarseness..... Yes No
Meningitis..... Yes No
Liver problems..... Yes No
Prostate problems..... Yes No
Hepatitis..... Yes No
Colon infections..... Yes No

Any blood in bowel movement..... Yes No
Birth defects..... Yes No
Recurrent chest pains..... Yes No
Migraine headaches..... Yes No
Abnormal urinalysis..... Yes No
Extensive confinement by illness.....Yes No
Sleeping sickness.....Yes No
Syphilis..... Yes No
Genital Herpes.....Yes No
Chlamydia infection.....Yes No
Strep-throat.....Yes No
Bronchitis.....Yes No
Mononucleosis.....Yes No
Other_____

Ever had an electrocardiogram?..... Yes No

Ever had blood test for
Venereal Disease?..... Yes No

Have you ever considered suicide?..... Yes No

DO YOU OR NOW OR HAVE YOU HAD WITHIN THE PAST YEAR:

Change in size, shape, color
or texture of bowel movement.. Yes No
Pain on urination..... Yes No
Difficulty starting urination..... Yes No
Frequent urination..... Yes No
Any blood in urine..... Yes No
Any blood in bowel movement. Yes No
Loss of urine on coughing or
sneezing..... Yes No
Persistent joint pain or swelling Yes No

Muscle spasms..... Yes No
Hot Flashes..... Yes No
Tiredness, fatigue, weakness
without apparent reason..... Yes No
Wary bruising.....Yes No
Fainting Spells..... Yes No
Discharge from ears..... Yes No
Difficulty swallowing..... Yes No
Enlarged glands..... Yes No
Chest pains..... Yes No

Coughed up blood..... Yes No
Night Sweats..... Yes No
Wake up at night short of breath..... Yes No
Swelling of hands, feet, ankles..... Yes No
Leg Cramps..... Yes No
Purple lips or fingers..... Yes No
Vomited blood..... Yes No
Sores around sexual organs..... Yes No
Persistent nose bleeds..... Yes No

WOMEN ONLY;

Menstrual cycle regular..... Yes No
Normal menstrual flow..... Yes No
Any clots past..... Yes No
Pains or cramps during period...Yes No
Date of last period_____
Age period started_____
Date of last pelvic exam_____
Date of last Pap smear_____
Negative ___ Positive___

Any vaginal discharge..... Yes No
Any itching of vaginal area..Yes No
Do you take birth control pills Yes No
Any in between period spotting Yes No
Any pain during intercourse.... Yes No

Are you currently pregnant..... Yes No
Pregnancies_____Children_____
Miscarriages_____Abortions_____
Cesarean Sections_____
Multiple Births_____
Breech Deliveries_____

Please give additional information on any difficult pregnancy, delivery complications, and/or menstrual problems:_____

ALLERGIES

Penicillin ..... Yes No
Aspirin ..... Yes No
Codeine ..... Yes No
Morphine ..... Yes No
Demerol ..... Yes No
Mycins ..... Yes No
Tetracycline ..... Yes No
Darvon ..... Yes No
Tetanus shot ..... Yes No
Sedatives ..... Yes No
Sleeping pills ..... Yes No
Asthma drugs ..... Yes No
Sulfa ..... Yes No
Local anesthetics ..... Yes No
Any food allergy (To what?) ... Yes No

_____

Any other drugs ..... Yes No
Iodine ..... Yes No

FRACTURES OR ACCIDENT INJURIES

Have you ever had: .....
Broken or cracked bones ..... Yes No
Where _____
Severe lacerations ..... Yes No
Where _____
Dislocations ..... Yes No
Where _____
Concussion ..... Yes No
When _____
Head injury ..... Yes No
When _____
Ever been knocked unconscious ..... Yes No

SOCIAL

Drug problem ..... Yes No
Adequate dietary habits ..... Yes No
Alcohol ..... Yes No
How much? _____
Tobacco ..... Yes No
How much? _____
Ever been treated for drug habits .. Yes No

Are you? Right-handed Left-handed Both
Height _____ Weight Now _____
1 yr. ago _____

What kind of work are you doing now?

_____

What was your occupation prior to this injury?

_____

Marital Status: M W S D

SURGERY: Have you ever had:

Prostate ..... Yes No
Tonsillectomy ..... Yes No
Appendectomy ..... Yes No
Hysterectomy ..... Yes No
Ovarian cysts ..... Yes No
Breast Tumors, cysts ..... Yes No
Ear surgery ..... Yes No
Eye surgery ..... Yes No
Gall bladder ..... Yes No
Stomach ..... Yes No
Hernia (rupture) ..... Yes No

Hemorrhoids (piles) ..... Yes No
Varicose veins ..... Yes No
Neck surgery ..... Yes No
Thyroid surgery ..... Yes No
Nose surgery ..... Yes No
Heart surgery ..... Yes No
Wisdom teeth extractions ..... Yes No
Any other operations ..... Yes No
Type _____
Type _____
Blood transfusions ..... Yes No

Have you ever been advised to have any surgery which has not been done? ..... Yes No
Have you been hospitalized for any illnesses ..... Yes No
Give details of yes answers: _____

IS THERE ANY FAMILY HISTORY OF THE FOLLOWING:

Cancer ..... Yes No
Heart Trouble ..... Yes No
Tuberculosis ..... Yes No
Mental Health ..... Yes No
High Blood Pressure ..... Yes No
Stroke ..... Yes No
Diabetes ..... Yes No
Seizure ..... Yes No
Muscle Disease ..... Yes No

MEDICATIONS:

Are you now taking or have taken in the past either regularly or periodically?

Digitalis ..... Now Past
Water or salt losers (Diuretics) .. Now Past
Birth Control Pills ..... Now Past
Thyroid or Antithyroid ..... Now Past
Anti-depressants ..... Now Past
Tranquilizers ..... Now Past
Allergy pills ..... Now Past
Pep or diet pills ..... Now Past
Blood thinner ..... Now Past
Laxatives ..... Now Past
Asthma medicine ..... Now Past
Iron medicine ..... Now Past
Aspirin ..... Now Past
Nitroglycerin ..... Now Past
Male Hormone ..... Now Past

Female hormones ..... Now Past
Sulfa Drugs ..... Now Past
Antibiotics ..... Now Past
Narcotic pain relievers ..... Now Past
Vitamins ..... Now Past
Cortisone ..... Now Past
Allergy shots ..... Now Past
Weight control pills ..... Now Past
Cough medicine ..... Now Past
Anticoagulants ..... Now Past
Quinine ..... Now Past
Other _____ Now Past
_____ Now Past
_____ Now Past
_____ Now Past

List all medication and dosages you are currently taking or bring list of all medications:

_____
_____
_____
_____
_____
_____
_____
_____

VACCINATIONS, IMMUNIZATION AND/OR DISEASE:

INDICATE: V-Vaccination D-Disease

_____ Measles (3-day) _____ Small Pox _____ Hepatitis B _____ Tetanus _____ Chicken Pox

_____ Measles (10-day) _____ Yellow Fever _____ Mumps _____ Pertussis

_____ Polio _____ Typhus Fever _____ Diphtheria _____ Typhoid

CURRENT PROBLEM:

Why are you here today? _____

_____

Date of onset? _____ Is your pain getting? Worse Better Remaining Constant

Where is your pain the worst? BACK NECK LEGS ARMS HEAD

What time of the day is your pain worse? _____

Circle what activities make the pain worse:

Exercise	Walking	Coughing	Sitting	Bending forward
Resting	Sneezing	Lying Down	Standing	Bending backward

Circle what reduces the pain:

Lying down	Manipulation	Muscle Relaxants	Walking
Sitting	Standing	Physical Therapy	Pain Pills

Does your pain keep you from the following?

Working	Exercising	Sleeping
Having Fun	Sports	No Limitations

Do you need to rest during the day due to your pain?

None A little Half the day Over half the day

Do you have? Numbness Where? _____

Weakness Where? _____

Do you have difficulty with? Bowel Bladder Sexual function (painful or unable)

List doctors currently treating you for these problems:

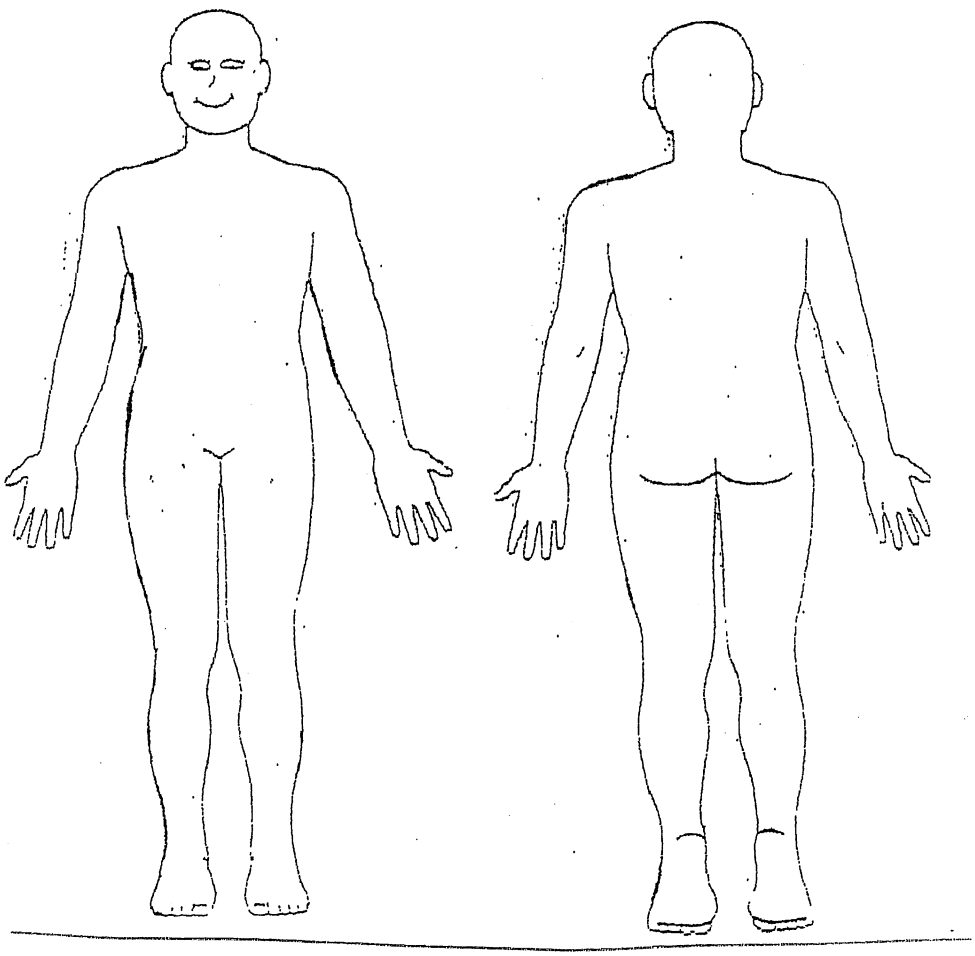
_____

Use the body charts below and draw on them where you pain is located. Please use the following symbols to show what kind of pain you are having in these areas. At the bottom, estimate the severeness of your pain by circling on of the numbers. (1 would be no pain , and 10 would be intolerable pain.)

Ache	Burning
////	B B B
///	B B

Numbness	Pins & Needles
X X X	= = = =
X X	= = =

Stabbing	Other
Z Z Z	O O O
Z Z	O O



1 2 3 4 5 6 7 8 9 10

SCALE OF PAIN

LEAST WORST