

## Apex Pain Specialists - Follow-Up Patient Medical History Intake Form

Name \_\_\_\_\_ Age \_\_\_\_\_ Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Referred By: \_\_\_\_\_

What problem/issue brings you here today?

Since your last physician visit, are your symptoms:

Better

Worse

Unchanged

Have you undergone any treatment since last visit? Was it helpful?

Please make a mark on the line below to indicate the level of discomfort you have today

No Pain \_\_\_\_\_ Worst Pain Ever

0      1      2      3      4      5      6      7      8      9      10

Please describe what the pain feels like:

Dull    Sharp    Achy    Burning    Cold    Crampy    Numbness

Shooting    Stabbing    Throbbing    Tingling    Tight

Please draw where you have pain or discomfort

Please describe the time course of your pain:

Constant    Intermittent    Worsening    Improving    Unchanging

What makes it better?

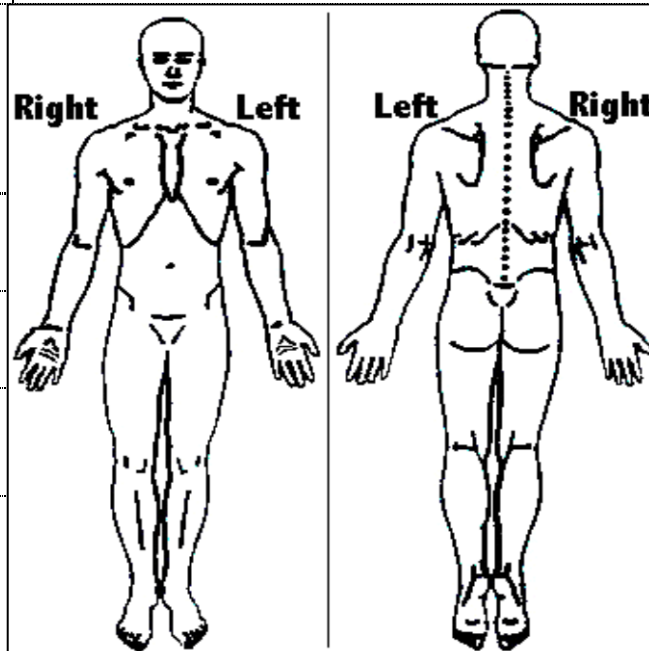
What makes it worse?

Do you have any associated symptoms?

None    Tingling    Numbness    Arm/Leg Weakness    Incontinence

What do you do for exercise?

Do you use a cane or walker?



List activities you are now unable to perform because of pain. Is your sleep affected by the pain?

Current Medications: *any new medications?*

Allergies: *Reaction?*

Any New Medical problems, surgeries, or allergies?

**Family History:** *Please circle all that apply*

Bipolar disorder	Heart disease	Cancer	Depression
Diabetes	High blood pressure	Substance abuse	Arthritis

**Social History: Marital Status:** *Any change in status since last visit?*

	Current	Quit (When)	Never		
<b>Tobacco use</b> (cigarette, cigar, pipe, chew):					
<b>Illicit drug use</b> (cocaine, marijuana, heroin, ecstasy, PCP):					
<b>Opioid use</b> (hydro/oxycodone, morphine, oxycontin, fentanyl):					
<b>History of substance abuse/addiction?</b>					
<b>Number of alcoholic beverages per week?</b>					
<b>Occupation:</b>					
<b>Employment Status:</b>	Full-time	Part-time	Light Duty	Off Duty due to injury	Full-time Parent

**Review of Symptoms: Please indicate by circling if you are experiencing any of the following symptoms**

Fatigue	Fever	Loss of appetite	Unintentional weight loss			
Change in vision	Loss of vision	Double vision	Difficulty swallowing			
Chest pain	Irregular heartbeat	Leg swelling	Cold extremities			
Shortness of breath	Wheezing	Cough				
Nausea	Vomiting	Black/bloody stools	Loss of control of stools	Constipation	Heartburn	
Loss of control of urine	Urinary frequency	Difficulty urinating	Pain/burning on urination			
Possibly pregnant	Painful intercourse					
Easy bleeding	Easy bruising	Taking blood thinners	Enlarged lymph nodes			
New rash	Dry/sensitive skin					
Arm/leg weakness	Numbness	Tingling	Dizziness	Loss of balance	Headache	Seizures
Back/neck pain	Joint pain	Joint swelling	Muscle cramps/pain			
Anxiety	Serious depression	Sleep disturbance	Suicidal thoughts			