HEALTH HISTORY INTAKE QUESTIONS

Center for Pain Management, Meridian MRI, Center for Special Surgery

A representative of our practice will call 2 to 3 days prior to your first appointment to complete the following HEALTH HISTORY. Please review these questions in advance to shorten the length of time needed for the phone call.

ALLERGIES:

Do you have a Latex allergy? Yes/No

Please list all allergies and reactions you have: ____

____

FAMILY HISTORY:

Please circle any of the following that are present in your family members

Adverse Reaction to Anesthesia	Diabetes Mellitus	Mental Illness
	Fibromyalgia	Migraines
	Heart Disease	Rheumatoid Arthritis
Cancer	Hypertension	Seizure Disorder
Chronic Pain	Lung Disease	Stroke

PAST MEDICAL:

Please circle any of the following for which you have ever received treatment

Alcohol Abuse	Drug Dependence	Obstructive Sleep Apnea
Anemia	Gastric Ulcer	Postmenopausal
Anesthesia Complications	Head Injury	Osteoporosis
Anxiety Disorder	Heart Disease	Psoriasis
Arthritis	Hepatitis B	Psychological Trauma
Asthma	Hepatitis C	Seizure Disorder
Bleeding Disorders	Hiatal Hernia	Sexually Transmitted Disease
Cancer[type:______________]	HIV	
Coagulopathy	Hypercholesterolemia	Spinal Cord Injury
Congestive Heart Failure	Hypercoagulopathy	Spinal Fusion
COPD	Hypertension	Thrombophlebitis
Coronary Artery Disease	Hyperthyroidism	Transient Cerebral Ischemia
CVA (stroke)	Hypothyroidism	Tuberculosis
Depression	Kidney Disease	Urinary Tract Infection
Diabetes	Liver Disease	

Currently on a blood thinner? Yes / No

If yes please circle which one:

Aggrenox	Heparin
Coumadin	Lovenox
Effient	Prasugrel

Any medications containing NSAIDS (aspirin or ibuprofen)

I have had (or a family member has had) a problem (e.g. prolonged paralysis, awareness, malignant hyperthermia) under anesthesia: Yes / No

Immunizations: (date received)

Tetanus:____

Hepatitis: ____

TB test:____

Females:

Last menstrual period ________________________________

Are you or could you be pregnant?	Yes / No
Are your periods regular?	Yes / No / N/A
Hysterectomy?	Yes / No
Birth Control Pills?	Yes / No

PAST MEDICAL: (continued) Hospitalizations: (please list all major illnesses with diagnosis and year)

1.________________________ 2.________________________

3. ________________________ 4.________________________

5.________________________ 6. ________________________

Surgeries: (please list all surgeries and type along with year performed) (include spinal injections)

1.________________________ 2.________________________

3. ________________________ 4.________________________

5.________________________ 6. ________________________

When and where have you had any of the following: (list results, if known)

MRI(s): ________________________

CT(s): ________________________

X-ray(s): ________________________

Colonoscopy: ________________________

Mammogram: ________________________

SOCIAL HISTORY:
(please circle)

Race:
White
African American
Asian
Hispanic
Indian
Other___________

Language:
English
Spanish
Other:__________

Marital Status:
Single
Married
Divorced
Widowed

I currently live in a:
House
Apartment
Mobile Home
Retirement Center

Education:
Some High School (Grade________)
High School Graduate
Some College
College Graduate
Masters
Doctorate

Annual Household Income:
less than $10,000
$10,0001 to $20,000
$20,001 to $40,000
$40,001 to $100,000
$100,001+

Job History:
do not work
less than 20 hrs/week
20-40 hrs/wk
40hrs or more/week
retired
disability
applying for disability
missed work due to pain
no missed work due to pain

JOB HISTORY:

Job Title:________________________ Years in current position:____________

Prior Job:________________________ Years in that position: ______________

If you are currently NOT WORKING what was the exact date you last worked:____________________

If you are disabled, what year were you declared disabled? ______ By whom? ____________________

How much do you lift on your job?________________________ How often? ____________________

Tobacco Use: Do you smoke? Yes / No How many packs per day?

Did you ever smoke? Yes / No Do any immediate relatives smoke? Yes / No

Alcohol Use: How many drinks do you have per week?

How many times in a year do you have more than four drinks in one day?

Have you ever been treated for alcohol dependency? Yes / No

Do any of your immediate relatives have or had an alcohol problem? Yes / No

Substance Abuse: Do you currently use: marijuana, cocaine, crack, ecstasy, methamphetamines, any other ________________________ drugs off the street? Yes / No

Have you in the past used any of the above? Yes / No

Do any of your first degree relatives have a substance abuse problem? Yes / No

Have you ever been treated for substance abuse? Yes / No

Caffeine Use: How many caffeinated beverages do you drink per day? ________________________

MEDICATION HISTORY: Please list all current pain medication with mg doses and frequency (times taken per day):

1. ________________________________ 2. ________________________________

3. ________________________________ 4. ________________________________

5. ________________________________ 6. ________________________________

Please list all other medication taken including over the counter, weight loss and nutraceuticals:

1. ________________________________ 2. ________________________________

3. ________________________________ 4. ________________________________

5. ________________________________ 6. ________________________________

REVIEW OF SYSTEMS: Please indicate if you have any of the following conditions or symptoms. Circle all that apply.

General Health:
Chills
Fatigue
Fever
Night Sweats
Weight Gain >10lbs
Weight Loss >10lbs

Skin:
Change in Wart/Mole
Dryness
Excessive Sweating
Hair Loss
Nail Changes
New Lesions
Rash
Skin Color Changes

HEENT:
Bleeding Gums
Blurred Vision
Double Vision
Head Injury
Hearing Loss
Hoarseness
Nose Bleed
Ringing in Ears
Sinus Pain
Vertigo
Visual Loss

Neck:
Neck Mass
Neck Stiffness
Swollen Glands

Breast:
Breast Mass
Breast Pain
Nipple Discharge
Skin Changes

Cardiovascular:
Calf Cramps
Chest Pain
Difficulty Breathing Lying Down
Fainting/Blacking Out
Irregular Heart Beat
Shortness of Breath
Swelling of Extremities

Gastrointestinal:
Abdominal Pain
Black Tarry Stool
Bloody Stool
Change in Bowel Habits
Constipation
Diarrhea
Difficulty Swallowing
Heartburn
Jaundice
Nausea
Rectal Bleeding
Vomiting
Vomiting Blood

Musculoskeletal:
Joint pain
Joint Stiffness
Joint swelling
Muscle atrophy
Muscle weakness

Neurological:
Decreased Memory
Difficulty Speaking
Dizziness
Headaches
Incontinence Stool
Incoordination
Loss of Consciousness
Seizures
Stroke
Unsteadiness

Psychiatric:
Anxiety
Change in Sleep Pattern
Depression
Hallucinations
History of abuse
Mood Changes
Panic Attacks
Suicidal Ideation

Endocrine:
Cold Intolerance
Excessive Thirst
Excessive Urination
Hair Changes
Heat Intolerance
Hot Flashes
Libido Change
Sexual Dysfunction
Thyroid Problems

Hematology:
Abnormal Bleeding
Anemia
Blood Clots
Easy Bruising
Prolonged Bleeding

Other Medical Problems: ____

Information Provided by: ___________________________________ Date: ____