Piedmont HealthCare

PAIN & SPINE CENTER

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Fellowship Trained & Board Certified in Pain Medicine

New Patient Visit

Date: _____ Patient Name: _____ DOB: _____

BEST Phone# to contact you _____ (□Cell □Home) **E-mail:** _____

1. Pain Location & Radiation: Where do you hurt? Check **(✓).**

□Low back pain □Both sides □Only the Right side □Only the Left side	**pain radiates to**	□No radiation □Both legs □Only the right leg □Only the Left leg	**how far down the leg**	□Thigh □Knee □Calf □Ankle □Foot □Toes	**AND**	□Right buttock pain □Left buttock pain □Bilateral buttock pain

Do you have any of the following symptoms?				
Numbness in legs	□ No □Yes	Where **=>**	□ Constant	□ Intermittent
Tingling in legs	□ No □Yes	Where **=>**	□ Constant	□ Intermittent
Weakness in legs	□ No □Yes	□Because of pain (but no strength problem) □Decreased muscle strength: describe **=>**		

□Neck pain □Both sides □Only the Right side □Only the Left side	**pain radiates to**	□No radiation □Both arms □Only the right arm □Only the Left arm	**how far down the arm**	□Upper arm □Elbow □Forearm □Hand □Fingers	**AND**	□Right shoulder blade pain □Left shoulder blade pain □Bilateral shoulder blade pain

Do you have any of the following symptoms?				
Numbness in arms	□ No □Yes	Where **=>**	□ Constant	□ Intermittent
Tingling in arms	□ No □Yes	Where **=>**	□ Constant	□ Intermittent
Weakness in arms	□ No □Yes	□Because of pain (but no strength problem) □Decreased muscle strength: describe **=>**		

□Pain in other region (example mid back pain, right knee pain etc.) =>

2. Pain Severity: Please circle a number that best describes your pain.

	0 = No pain										**10 = Worse possible pain**
Pain score **Today**	0	1	2	3	4	5	6	7	8	9	10
Least pain score on a typical day	0	1	2	3	4	5	6	7	8	9	10
Worst pain score on a typical day	0	1	2	3	4	5	6	7	8	9	10

3. Modifying Factors & Associated Symptoms:

What makes your pain WORSE (aggravating Factors) =>
What makes your pain BETTER (relieving Factors) =>
Do you have any of the following symptoms?

Muscle Spasms	□ No □Yes
Sleep disturbance (because of pain)	□ No □Yes

4. Medications: What medications are you taking **<u>for this problem</u>** and for how long have you been taking them?

Narcotic Pain Medications	For how long have you been taking it	How many pills per day	When was your last dose	Is it helping	Any side effects
				□Yes □No	□No □Yes, list **=>**
				□Yes □No	□No □Yes, list **=>**

Other Medications	For how long have you been taking it	N/A	Is it helping	Any side effects
			□Yes □No	□No □Yes, list **=>**
			□Yes □No	□No □Yes, list **=>**

5. Past Treatment: Which of the following treatments have you tried for pain relief in the past?

Treatment	No	Yes	**Circle all that apply**
Activity Modification			
Home Exercise Program			
Heat			
Ice			
Massage Therapy			
Acupuncture			
Chiropractic			
TENS unit			□helps □does not help
Brace			□Low back brace □Neck brace □Knee brace **=>** □OTC □medial grade; □helps □does not help
Have you had **Physical Therapy** <u>for this problem</u>			If yes, when: where:
OTC (over the counter) Meds			Aleve Advil Ibuprofen Tylenol Goody powder
Prednisone dose pack			
NSAID'S (Anti-Inflammatory Meds)			Naproxen Diclofenac Ibuprofen Celebrex Meloxicam Relafen Piroxicam Etodolac Arthrotec Indocin Daypro Ketoprofen Vimovo Duexis
Topical Agents (OTC & Prescription)			OTC pain patches Icy hot Biofreeze Bengay Asperecreme Lidoderm patch Volteran gel Flector patch Compounding cream
Muscle relaxants			Flexeril Zanaflex Robaxin Skelaxin Norflex Baclofen Parafon-Forte Soma
Anticonvulsants			Gabapentin Lyrica Topamax Gralise Keppra Horizont Tegretol Lamictal Trileptal Trokendi
Antidepressants			Amitriptyline Nortriptyline Cymbalta Effexor Savella
Opioids/Narcotic Pain Medications			Tramadol Codeine Vicodin Lortab Hydrocodone Oxycodone Percocet Morphine Opana Nucynta OxyContin Fentanyl patch Dilaudid Embeda Exalgo Butrans patch Hysingla ZoHydro Belbuca Oxaydo Xtempza
Have you seen any Pain Clinics in the past			If yes, which clinic/doctor:
Have you had any injections for this problem? (epidural injections, trigger injections etc)			If yes, what kind of injections:
Have you ever been discharged from a pain clinic?			If yes, which clinic & why:
Have you ever been treated with Suboxone, Subutex or Methadone for abusing or being addicted to narcotic pain medications			If yes, when & where:

6. **Blood Thinners:** Do you take any blood thinners? □No □Yes. If yes, please check **(✓)** all that apply.

□None □Savaysa (Edoxaban) □Eliquis (Apixaban) □Xeralto (Rivaroxaban) □Coumadin (Warfarin) □Pradaxa (Dabigatran)
□Brilinta (Ticagrelor) □Plavix (Clopidogrel) □Effient (Prasugrel) □Pletal (Cilostazol) □Aggrenox (Aspirin/Dipyridamole)
□Trental (Pentoxifylline) □Ticlid (Ticlopidine)

□Blood Thinner is prescribed by Dr. **=>**

7. **Pertinent Past Medical History:** Please check **(✓)** medical problems you currently have or had in the past.
   - Hematologic: □Blood clots in legs (DVT) □Blood clots in lungs (PE)
   - Bleeding disorder: □Thrombocytopenia □Hemophilia □Other: _____
   - Gastrointestinal: □Acid Reflux (GERD) □GI ulcers □GI bleeding
   - Cardiovascular: □Coronary artery disease □Heart attack (MI) □Heart stents □Atrial Fibrillation □High Blood pressure □Congestive heart failure □Pacemaker implant □Defibrillator implant
   - Kidney: □Decreased Kidney Function □On Dialysis (ESRD)
   - Respiratory: □COPD □Obstructive Sleep Apnea
   - Rheumatologic: □Fibromyalgia □Rheumatoid Arthritis □Lupus (SLE) □Psoriatic Arthritis □Gout
   - Neurological: □Peripheral Neuropathy □Stroke □Seizures (epilepsy) □Migraine Headaches
   - Endocrine: □Diabetes

8. **Pertinent Past Surgical History:** Please check **(✓)** surgeries you have had in the past. (Do not need exact dates; month/year is okay)
   - Low back surgery: □No □Yes if yes, by which surgeon & when: _____
   - Neck surgery: □No □Yes if yes, by which surgeon & when: _____
   - □Open heart surgery (CABG)
   - □ Gastric-bypass surgery □Lap-band surgery
   - □Knee replacement (Circle: Right Left Both)

9. **Social History:**
   - **Employment Status/Occupation:**
     □Employed, list your occupation _____

     □Unemployed □Disabled □Retired □Homemaker □Student
   - **Smoking**: □No □Yes
     If yes, packs per day? _____
   - **Alcohol Use**: □No □Yes
     If yes, ○drink socially ○drink regularly, how many drinks per week? _____
   - **Illegal Drug Use** (cocaine, meth, heroine etc): □No □Yes
     If yes, which drug _____

10. **Psychiatric History:** Please check **(✓)** psychiatric problems you currently have or had in the past.
    □None (no psyche history) □Depression □Anxiety □ADD □Bipolar Disorder □Other: _____

11. **Substance Abuse History:**
    Personal History of
    - Alcohol abuse: □No □Yes
    - Illegal drug abuse: □No □Yes
    - Prescription drug abuse: □No □Yes

I certify that the above information is correct to the best of my knowledge.

Patient Signature: _____