Barr Center for Innovative Pain & Regenerative Therapies

Medical History Questionnaire

DATE: ______________________

Name: ______________________ Age: ______ ☐ Right-Handed ☐ Left Handed

Referring Physician: ______________________ Primary Care Physician (PCP): ______________________

Preferred Pharmacy: ______________________ Phone: ______________________

Pharmacy Address: ______________________ City: ______________________

Reason for Visit: ______________________

Was there an initiating event for your pain? ☐ Yes ☐ No. If yes, please describe the event and any initial treatment

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PAIN CHARACTERISTICS:

Describe your pain: ☐ Aching ☐ Burning ☐ Stabbing ☐ Sharp ☐ Shooting ☐ Numbness ☐ Pulsating ☐ Tingling ☐ Weakness ☐ Other: ______________________

Does the pain shoot or refer to another part of the body? ☐ Yes ☐ No

If yes, where? ______________________

Your pain is: ☐ constant ☐ Intermittent ☐ occasional ______________________

How many hours per day do you have pain? _______ Hours/day ______________________

How long have you been in pain? ______________________

Do you occasionally need to stop all activities because of pain? ☐ Yes ☐ No

If yes, number of times? ☐ Daily _______ ☐ Weekly _______ ☐ Monthly _______ ☐ Yearly _______

Have you ever previously experienced this type of pain? ☐ Yes ☐ No

If yes, what was done for you? ______________________

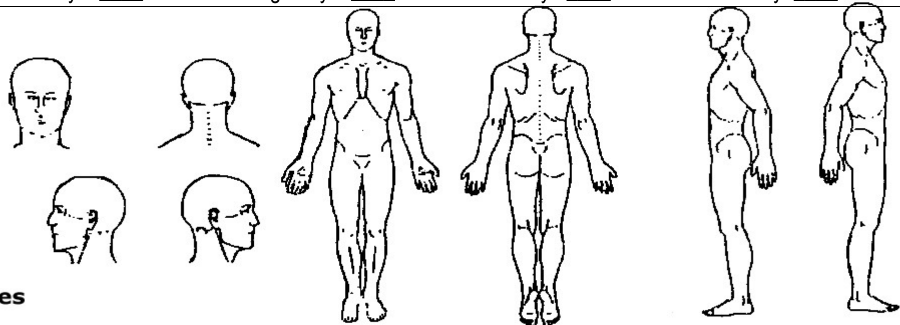
Pain Analogue Scale:	*No Pain*	*Minimal*	*Moderate*	*Intense*	*Emergency*
	0	*1 2 3*	*4 5 6*	*7 8 9*	*10*

Pain Diagram:

Please rate your pain: Today: ____ /10 Average day: ____ /10 Good Day: ____ /10 Bad Day ____ /10

- Please mark the areas of your pain. You may use the key to indicate different kinds of pain sensations.
- Please number each painful area in order of the most troublesome, i.e., 1-10 on the diagram.

Key:
- → - **shooting**
- /// - **stabbing**
- xxx - **aching**
- 000 - **throbbing**
- ●●● - **pins & needles**
- ••• - **burning**



Alleviating Factors: What makes your pain better? (please check all that apply)

☐ Medication ☐ Heat ☐ TENS ☐ Massage ☐ Traction ☐ Rest ☐ Movement ☐ Activity ☐ Exercise ☐ Stretching ☐ Sleep ☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Nothing

☐ Other: ______________________

Exacerbating Factors: What makes your pain worse? (please check all that apply)

☐ Movement ☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Driving ☐ Sleep ☐ Lack of sleep ☐ Stretching ☐ Exercise ☐ Bending ☐ Lifting ☐ Coughing ☐ Sneezing ☐ Tension ☐ Reaching over head ☐ Getting in/out of a chair ☐ Nothing

☐ Other ______________________

*****Please complete the following section ONLY IF you were involved in a motor vehicle accident.*****

Date of Accident: You were the: ☐ Driver ☐ Passenger in the ☐ front ☐ rear

You were: ☐ Rear-ended by another vehicle ☐ Rear-ended another vehicle ☐ Involved in a head on collision

☐ T-boned by another vehicle ☐ Driver's Side ☐ Passenger's side ☐You T-boned another vehicle

☐ Side-swiped driver's side ☐ Side-swiped on the passenger's side

You were the ☐ restrained ☐ unrestrained ☐ Driver ☐ Passenger in the ☐ front seat ☐ rear seat

Was there an air bag? ☐ Yes ☐ No Did it deploy? ☐ Yes ☐ No

Was anyone else injured in the accident? ☐ Yes ☐ No

Is there a Lawyer involved in your case? ☐ Yes ☐ No If yes, Name: ____

MEDICATION HISTORY

Please list all current medication (including over the counter medications) ***Please feel free to attach additional sheets if necessary.***

Medication	Indication	Dose	Prescribing Physician

ALLERGIES

☐ **NO KNOWN DRUG ALLERGIES** ☐ Iodine ☐ Contrast Dye (IVP) ☐ Latex

Please list drug allergies, type or reaction and onset date, if known: ____

Any severe allergic Reactions (Anaphylaxis) to anything? ☐ Yes ☐ No If yes, to what, type of reaction and onset date:

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REVIEW OF SYSTEMS

CONSTITUTIONAL ☐ Fever ☐ Weight Loss ☐ Weight Gain ☐ Weakness ☐ Fatigue ☐ Difficulty Sleeping ☐ Chills ☐ Night Sweats

EYES ☐ Visual Problems ☐ Glaucoma

HENT ☐ Headaches ☐ Sinus Problmes ☐ Hearing Problems ☐ Sleep Apnea

CARDIOVASCULAR ☐ Heart Trouble ☐ Swelling of feet ☐ Hypertension ☐ Lower Extremity Swelling

RESPIRATORY ☐ Cough ☐ Shortness of Breath

GASTROINTESTINAL ☐ Liver Disease ☐ Hepatitis ☐ Gall Bladder Problems ☐ Reflux ☐ Bowel Problems ☐ Consitpation ☐ Diarrhea

GENITOURINARY ☐ Kidney Stone ☐ Kidney Disease ☐ Bladder Problems ☐ Blood in Urine ☐ Reduced Libido (desire for sex)

INTEGUMENT ☐ Dry Skin ☐ Rashes

NEUROLOGICAL ☐ Seizures ☐ Stroke ☐ Peripheral neuropathy ☐ Numbness ☐ Memory or concentration difficulties
☐ Loss of Balance ☐ Falls ☐ Head Injuries

MUSCULOSKELETAL ☐ Neck Pain ☐ Shoulder Pain ☐ Elbow Pain ☐ Wrist/Hand Pain ☐ Carpal Tunnel Syndrome
☐ Low Back Pain ☐ Hip Pain ☐ Knee Pain ☐ Foot/Ankle Pain ☐ Gout

ENDOCRINE ☐ Thyrod Problem ☐ Diabetes ☐ Excessive Thirst

PSYCHIATRIC ☐ Depression ☐ Anxiety ☐ Anger ☐ Guilt

HEME-LYMPH ☐ Easy Bruising ☐ HIV Exposure ☐ Bleeding Problems

ALLERGIC-IMMUNOLOGIC ☐ Seasonal Allergy Allergies ☐ Anaphylactic (Severe) Medication Allergies ☐ Anaphylactic (severe) Reaction to Bee Stings

PAST MEDICAL HISTORY

☐ **No significant Past Medical History**
☐ Alzheimer's disease/Dementia
☐ Anxiety
☐ Asthma/COPD
☐ Atrial fibrillation
☐ CANCER-Type: ________________
☐ Cardiac pacemaker
☐ Chronic Regional Pain Syndrome (CRPS)
☐ Depression
☐ DVT (blood clot)
☐ Ehler's Danlos Syndrome
☐ Gastric ulcer
☐ Glaucoma
☐ Head Injury or Concussion
☐ Heart Disease (Coronary Artery Disease)
☐ Heart Failure
☐ Hernia
☐ High Cholesterol
☐ HIV/Aids Disease
☐ Hypertension (High Blood Pressure)
☐ Irritable Bowel Syndrome
☐ Kidney Disease
☐ Lupus
☐ Lyme Disease
☐ Marfan Syndrome
☐ Migraines
☐ Osteoporosis
☐ Parkinson's Disease
☐ Peripheral Neuropathy
☐ Peripheral Vascular Disease
☐ Rheumatoid arthritis
☐ Seizure disorder
☐ Shingles
☐ Sleep Apnea
☐ Stroke (CVA)
☐ Other Past Medical History:

SURGICAL HISTORY

☐ **No Pertinent Past Surgical History**

Please list all surgeries: ____

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PREVIOUS TREATMENT

☐ Physical Therapy
☐ TENS
☐ Chiropractic
☐ Psychological support ☐ Yes ☐ No Name: ______________
☐ Work Hardening
☐ Injections: ____
☐ Acupuncture
☐ Other: ____

Pain Clinics ☐ Yes ☐ No If yes, Where: ____ When? ________________

FAMILY MEDICAL HISTORY

☐ **No Significant Family History** ☐ **Family History Unknown**

Condition:	Relative	Age	Condition	Relative	Age
☐ Cancer: TYPE: ____________________			☐ High blood pressure (Hypertension)		
☐ Diabetes			☐ Stroke		
☐ Heart disease (coronary artery disease)					

☐ **Other Family Medical Problems:** ____

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SOCIAL HISTORY

☐ Able to care for self
☐ Able to drive
☐ Climbs stairs daily
☐ Regular exercise

Alcohol:
☐ Denies use ☐ Occasional use
☐ more than 15 drinks/week

Marital status:
☐ Single ☐ Married
☐ Divorced/separated ☐ Widow/Widower

Smoking: ☐ Denies
☐ Admits to smoking (____ packs/day) ☐ Former Smoker: Date Quit: _______

Substance Abuse : ☐ Denies
☐ In past (including alcohol)
☐ Use of illegal drugs in the last year

Work status:
☐ Student
☐ Does not work outside the home: ☐ Disabled ☐ Retired
☐ Works outside the home

Occupation: ____

Other important social issues: ____

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