MD PAIN

MEDICAL HISTORY FORM

DATE:______________________ REFERRED BY:______________________

NAME:______________________ FAMILY DOCTOR:______________________

PREFERRED NAME:______________________ PREFERRED PHARMACY:______________________

AGE:__________ DATE OF BIRTH:______________ HT:______________ WT:__________

CHIEF COMPLAINT:

DESCRIPTION OF SYMPTOMS (SELECT ONE)

- PAIN
- NUMBNESS/TINGLING
- OTHER______________________

LOCATION:______________________

PAIN RADIATES FROM/TO:______________________

IS THE PROBLEM A RESULT OF AN INJURY OR ACCIDENT?

- NO INJURY
- INJURY AT WORK
- AUTO ACCIDENT
- SPORTS INJURY
- PRIOR SURGERY

HOW LONG HAVE THE SYMPTOMS BEEN PRESENT?______________________

DESCRIBE THE ONSET:

- ACUTE (SUDDEN)
- CHRONIC CONDITION (>3 MONTHS)

ARE YOU RESPRESENTED BY AN ATTORNEY Y______________ N______________

HAVE YOU HAD A PROBLEM LIKE THIS BEFORE? Y__________ N__________

DESCRIBE:______________________

HAVE YOU BEEN SEEN IN THE ER FOR THIS PROBLEM? Y__________ N__________

TREATING ER:______________________ DATE:______________________

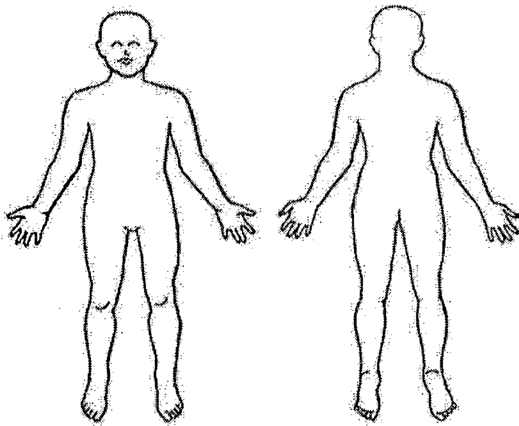
RATE THE PAIN (0 BEING NO PAIN , 10 THE MOST PAIN) 0 1 2 3 4 5 6 7 8 9 10

DO THE SYMPTOMS WAKE YOU FROM SLEEP? Y______________ N______________

DESCRIBE THE SYMPTOMS:

- SHARP
- DULL
- STABBING
- THROBBING
- ACHING
- BURNING
- SHOOTING

PLEASE SHADE IN AREA WHERE YOUR PAIN IS LOCATED



WHAT IS THE TIMING OF THE SYMPTOMS? CONSTANT______________ INTERMITTENT_____________

IS THE PROBLEM GETTING BETTER OR WORSE? GETTING BETTER_______GETTING WORSE_______UNCHANGED________

WHAT MAKES THE SYMPTOMS WORSE? SQUATTING KNEELING SITTING BENDING STAIRS TWISTING MOVING LYING IN BED RUNNING WALKING ATHLETICS STANDING GRIPPING LIFTING REACHING OVERHEAD

WHAT MAKES THE SYMPTOMS BETTER? LYING DOWN POSITION CHANGES SITTING STANDING MEDICATION NOTHING

ARE THERE ANY OTHER SYMPTOMS ASSOICATED WITH THIS PROBLEM? REDNESS BRUISING SWELLING NUMBNESS STIFFNESS LIMPING CLICKING LOCKING POPPING TINGLING WEAKNESS GIVING WAY

PRIOR TREATMENT/ TESTING

HAVE YOU HAD ANY PRIOR TESTS FOR THIS PROBLEM?

- NONE
- XRAYS
- MRI
- CT SCAN
- NERVE TEST (EMG)
- BONE SCAN

HAVE YOU HAD ANY PRIOR TREATMENT FOR THIS PROBLEM? Y____________________N__________________

TYPE OF TREATMENT:

ICE	IMPROVED	WORSENED	UNCHANGED
HEAT	IMPROVED	WORSENED	UNCHANGED
REST	IMPROVED	WORSENED	UNCHANGED
NSAIDS	IMPROVED	WORSENED	UNCHANGED
MUSCLE RELAXERS	IMPROVED	WORSENED	UNCHANGED
CHIROPRACTOR	IMPROVED	WORSENED	UNCHANGED
PHYSICAL THERAPY	IMPROVED	WORSENED	UNCHANGED
HOME EXERCISE	IMPROVED	WORSENED	UNCHANGED
SURGERY	IMPROVED	WORSENED	UNCHANGED
INJECTIONS	IMPROVED	WORSENED	UNCHANGED
BRACING	IMPROVED	WORSENED	UNCHANGED
TENS UNIT	IMPROVED	WORSENED	UNCHANGED

OTHER____

SURGICAL HISTORY: SELECT ALL PREVIOUS HOSPITALIZATIONS/SURGERIES: NONE__________

- ANEURYSM SURGERY AORTIC BYPASS/VASCULAR SURGERY APPENDECTOMY CATARACT SURGERY
- CHOLECYSTECTOMY HEART SURGERY HERNIA REPAIR HYSTERECTOMY
- LAP BAND/GASTRIC BYPASS LUMPECTOMY MASTECTOMY CANCER/MALIGNANCY
- OTHER____

ORTHOPEDIC SURGERY :

- ARTHROSCOPY KNEE R____L_____ ARTHROSCOPY SHOULDER R_____L______ CARPAL TUNNEL R____L_____
- TOTAL HIP REPLACEMENT R____L_____ TOTAL KNEE REPLACEMENT R_____L______ TOTAL SHOULDER R_____L_____
- SPINAL SURGERY LEVEL:_______________
- OTHER ORTHOPEDIC SURGERY____

MEDICAL QUESTIONS

MARK ALL THAT APPLY: METAL IN BODY_____ CLAUSTROPHOBIC _____ PREGNANT_____ SLEEP APNEA_____ CPAP_____ SNORES______

ARE YOU TAKING A BLOOD THINNER? Y_________________N________________

REVIEW OF SYSTEMS

PLEASE INDICATE IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS IN THE PAST SIX MONTHS

NONE FOR ALL______________

- **CON** WEIGHT LOSS LOSS OF APPETITE FATIGUE
- **EYE** BLURRED VISION DOUBLE VISION VISION LOSS
- **ENT** HEARING LOSS HOARSENESS TROUBLE SWALLOWING
- **CARDIO** CHEST PAIN PALPITATIONS
- **RESP** CHRONIC COUGH PNEUMONIA SHORTNESS OF BREATH
- **GI** HEARTBURN, ULCERS NAUSEA, VOMITING BLOOD IN STOOL
- **GU** PAINFUL URINATION BLOOD IN URINE KIDNEY PROBLEMS
- **SKIN** FREQUENT RASHES SKIN ULCERS LUMPS PSORIASIS
- **NEURO** FREQUENT FALLS LOSS OF COORDINATION NUMBNESS DIZZINESS
- **PSYCH** DEPRESSION/ANXIETY DRUG/ALCOHOL ADDICTION SLEEP DISORDER
- **ENDO** FEVER HEAT OR COLD INTOLERANCE NIGHT SWEATS
- **HEM** EASY BLEEDING EASY BRUISING ANEMIA

FAMILY HISTORY

FATHER NONE DIABETES HEART DISEASE HYPERTENSION BLEEDINGPROBLEMS

EPILEPSY CONNECTIVE TISSUE MUSCULAR DYSTROPHY STROKE OSTEOPOROSIS

RHEUMATOID ARTHRITIS CANCER

MOTHER NONE DIABETES HEART DISEASE HYPERTENSION BLEEDING PROBLEMS

EPILEPSY CONNECTIVE TISSUE MUSCULAR DYSTROPHY STROKE OSTEOPOROSIS

RHEUMATOID ARTHRITIS CANCER

SIBLING NONE DIABETES HEART DISEASE HYPERTENSION BLEEDINGPROBLEMS

EPILEPSY CONNECTIVE TISSUE MUSCULAR DYSTROPHY STROKE OSTEOPOROSIS

RHEUMATOID ARTHRITIS CANCER

SOCIAL HISTORY

DO YOU SMOKE? DAILY________ OCCASIONALLY_________ FORMER SMOKER__________ NEVER__________

DO YOU DRINK ALCOHOL? DAILY________ OCCASIONALLY_________ RARELY ___________ NEVER_______________

DO YOU HAVE A PAST HISTORY OF DRUG, ALCOHOL, OR SUBSTANCE DEPENDENCE? YES_________________ NO____________

MARITAL HISTORY MARRIED_____________ SINGLE__________ DIVORCED_________ WIDOWED________ DOMESTIC PARTNER__________

ARE YOU CURRENTLY WORKING? YES_____________ NO_____________ RETIRED__________ DISABLED____________

IF NO, WHAT DATE DID YOU LAST WORK? (MM/DD/YYYY)____________________WORK RESTRICTIONS?________________

OCCUPATION______________________________ EMPLOYER_______________________________________
STUDENT__________

MISCELLANEOUS

DO YOU HAVE ANY ALLERGIES? Y______________N____________

PLEASE LIST____

LATEX ALLERGY? Y_____________ N_______________

PLEASE LIST ALL MEDICATIONS YOU TAKE ON A REGULAR BASIS NONE________________

____

DO YOU HAVE A PERSONAL HISTORY OF ANY OF THE FOLLOWING? NONE____________________

ANEURYSM ANGINA ARTHRITIS ASTHMA BONE OR JOINT INFECTION
CANCER CHEMOTHERAPY/RAD COPD CONGESTIVE HEART FAILURE
DIABETES EMPHYSEMA EPILEPSY HEART ATTACK HEPATITIS
HIV/AIDS HIGHCHOLESTEROL HYPERTENSION HYPERTHYROIDISM HYPOTHYROIDISM
KIDNEY DISEASE KIDNEY STONES MRSA INFECTION PACEMAKER BLOOD CLOTS
PULMONARY EMBOLISM ANESTHESIA REACTION SEIZURES STOMACH ULCERS STROKE/TIA
TUBERCULOSIS

SOAPP® Version 1.0

Name: ______________________________ Date: ______________

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings? 0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? 0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs? 0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem? 0 1 2 3 4
6. How often have you attended an AA or NA meeting? 0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem? 0 1 2 3 4
9. How often have your medications been lost or stolen? 0 1 2 3 4
10. How often have others expressed concern over your use of medication? 0 1 2 3 4
11. How often have you felt a craving for medication? 0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse? 0 1 2 3 4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? 0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

ORT

For the following questions, place a check mark on the line if it applies to you.

1. Family history of substance abuse:

   Alcohol ______

   Illegal drugs ______

   Prescription drugs ______

2. Personal history of substance abuse:

   Alcohol ______

   Illegal drugs ______

   Prescription drugs ______

3. Age (check if 16-45 years old): ______

4. History of preadolescent sexual abuse: ______

5. Psychological Disease:

   Attention-deficit disorder, obsessive-compulsive
   Disorder, bipolar disorder, or schizophrenia ______

   Depression ______