

**PAIN CONSULTANTS OF ARIZONA IN COLLABORATION WITH HONOR HEALTH**

**Patient History Form**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Who referred you to see us? \_\_\_\_\_

Who is your PCP? \_\_\_\_\_

Chief Complaint: What is the main reason for your visit today?



**History of Present Illness**

Please answer the following questions:

Where is your worst pain? On the diagram to the right, best mark your **MOST** painful area (s) and describe briefly below.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When did you first notice the problem?

\_\_\_\_\_

**Cause (if known):**

- Work  Injury  Illness  Vehicular Accident
- Other \_\_\_\_\_

Does anything help or make the problem worse?

- Sitting  Standing  Walking
- Lying down  Sneezing/coughing  Exercising

Other: \_\_\_\_\_

**Associated Symptoms:**

- Weakness  Poor Sleep  Mood changes  Bladder/bowel incontinence

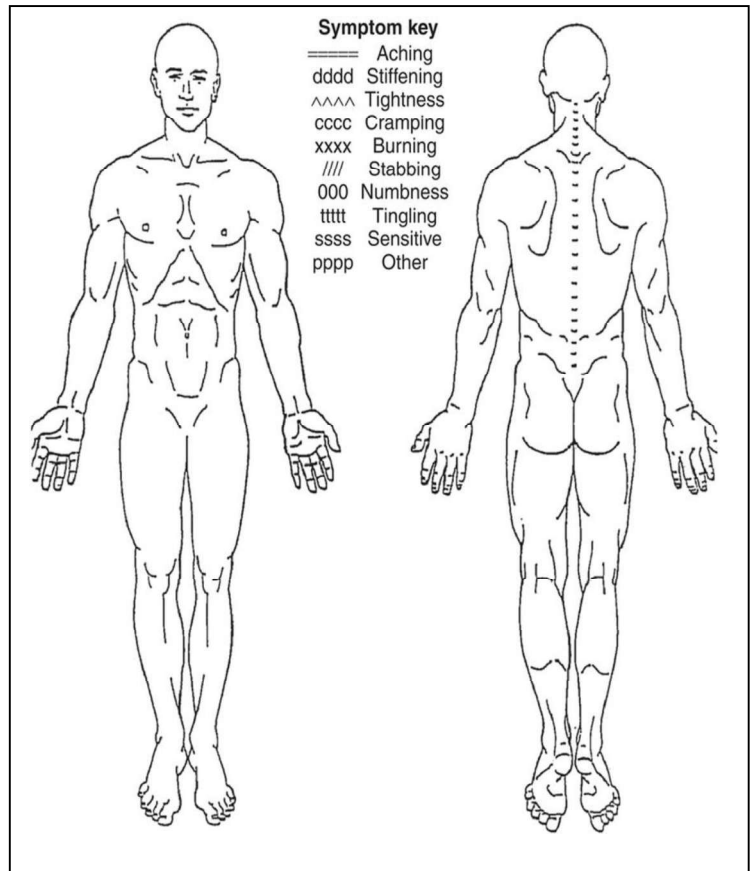
How long does the problem last?

- Minutes  Hours  Intermittent  Constant
- Other \_\_\_\_\_

\_\_\_\_\_

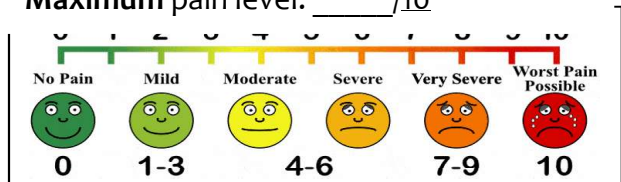
\_\_\_\_\_

\_\_\_\_\_



Average pain level: \_\_\_\_\_/10

Maximum pain level: \_\_\_\_\_/10



**PAST MEDICAL HISTORY:**

- |                       |                              |                             |                                |                              |                             |
|-----------------------|------------------------------|-----------------------------|--------------------------------|------------------------------|-----------------------------|
| Heart Disease         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Arrhythmia               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High blood pressure   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Seizures              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | COPD                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neuropathy                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sleep Apnea           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver disease/problems         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding disorder     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blood clots/pulmonary embolism | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rheumatoid Arthritis  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gout                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| GERD/Gastritis        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney disease/problems        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Psychiatric Condition | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                                |                              |                             |

If yes for any, briefly explain/describe the condition(s):

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Previous Hospitalizations/Surgeries/Serious Illness (and dates if known):

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Please list all **MEDICATIONS** you are currently taking and dose if known: (If you need more space, please use a separate sheet or you may provide us your own list).

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Please list any **ALLERGIES** (and reactions):  NONE

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**Allergic to:**     Iodine or IV contrast     Latex     Local Anesthetics     None of these.

Do you have a pacemaker, defibrillator, or other implantable electronic devices? **Yes / No**

If yes, please describe: \_\_\_\_\_

**Are you on blood thinners?**     Yes     No

**If yes, which blood thinners are you taking?**

- COUMADIN     PLAVIX     PRADAXA     AGGRENOX     ELIQUIS  
 XARELTO     PLETAL     TICLID     EFFIENT     BRILINTA

OTHER: \_\_\_\_\_

**SOCIAL HISTORY:**

**Marital Status:**     Single             Married             Separated  
                          Divorced             Widowed

**Occupation:**            **What is/was your primary occupation?**

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Full-time             Part-time             Retired  
 Not working             Disabled             Student

**Use of Alcohol:**             Never     Rarely     Occasional     Daily

**Use of Tobacco:**

Cigarettes             Yes     No  
Smokeless Tobacco     Yes     No

**Use of Illicit Drugs:**

Current             Yes     No    Explain: \_\_\_\_\_  
Past                 Yes     No    Explain: \_\_\_\_\_

**Use of Marijuana**

Current             Yes     No    Explain: \_\_\_\_\_  
Past                 Yes     No    Explain: \_\_\_\_\_

**If yes, do you have a current State of Arizona-issued Medical Marijuana Card?**             Yes     No

**PAIN CONSULTANTS OF ARIZONA, IN COLLABORATION WITH HONOR HEALTH**  
**Pain Treatment History Form**

To help us provide you with the best care possible and to appropriately document for insurance requirements, it is important for us to have as much information about any of the following treatments you may have tried.

**Treatment history details:**

**INJECTION TYPE:**

**Relief?    How much?    How long? / Most recent  
 (if known)**

- Physical Therapy
- Epidural steroid injection     Cervical     Thoracic     Lumbar
- Radiofrequency ablation     Cervical     Thoracic     Lumbar
- Trigger point injection (location) \_\_\_\_\_
- Joint injection (location) \_\_\_\_\_
- Spinal cord stimulator: device company? \_\_\_\_\_
- Other (i.e. chiropractic/acupuncture/massage)

**Yes / No**

<input type="checkbox"/>	<input type="checkbox"/>	_____%	_____ / _____
<input type="checkbox"/>	<input type="checkbox"/>	_____%	_____ / _____
<input type="checkbox"/>	<input type="checkbox"/>	_____%	_____ / _____
<input type="checkbox"/>	<input type="checkbox"/>	_____%	_____ / _____
<input type="checkbox"/>	<input type="checkbox"/>	_____%	_____ / _____

Please indicate any of the following **PAIN MEDICATIONS** that you have tried:

**HAVE YOU TRIED?**

**DID YOU GET RELIEF?**

	<b>YES</b>	<b>YES</b>	<b>/ NO</b>
<b>Anti-depressants</b>			
Amitriptyline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Duloxetine (Cymbalta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nortriptyline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Milnacipran (Savella)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Anti-seizure (nerve) medications</b>			
Gabapentin (Neurontin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregabalin (Lyrica)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NSAIDs (anti-inflammatories)</b>			
Celecoxib (Celebrex)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diclofenac (Voltaren)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen (Advil, Motrin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indomethacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meloxicam (Mobic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Naproxen (Aleve)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**HAVE YOU TRIED?**

**DID YOU GET RELIEF?**

**YES**

**YES / NO**

**Opioids**

Buprenorphine (Butrans, Belbuca)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buprenorphine (Suboxone, Subutex)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hydrocodone (Vicodin, Norco, Hysingla)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hydromorphone (Dilaudid/Exalgo)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oxycodone (Oxycontin/ Xtampza/Percocet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fentanyl patch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fentanyl-Cancer Pain (Lazanda, Subsys, Fentora)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Levorphanol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morphine (Embeda, Kadian, MS Contin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tapentadol (Nucynta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tramadol (Ultram)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Skeletal muscle relaxants**

Baclofen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carisoprodol (Soma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cyclobenzaprine (Flexeril)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metaxolone (Skelaxin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methocarbamol (Robaxin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tizanidine(Zanaflex)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Topicals / Patches**

Lidocaine patches (Lidoderm patches)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diclofenac (Flector)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compounded creams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Cannabidiol (CBD) – no THC**

**Medical Marijuana – with THC**

What other **PAIN MEDICATIONS** not listed above have you tried in the past not listed above? Please comment on relief (if any) and side effects (if any):

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