

Consultants in Pain Medicine, Inc.

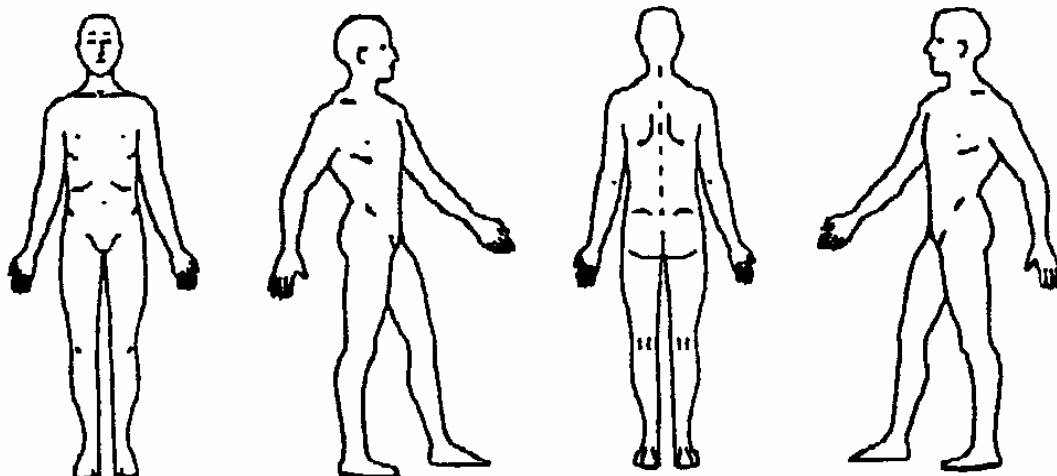
Please remember your fasting instructions, medication instructions, and to bring a driver. If you have not received this information, please call the office at 395-6450 or visit www.beachpain.com.

M.D. Signature _____

Name: _____ Age _____ Height _____ Weight _____ Date _____

Vitals: BP _____ HR _____ RR _____ T _____ SaO2 _____
(will be filled in at consultation)

Please mark exactly where your pain is located: ALLERGY: _____



When did you first notice your pain: _____

Did you injure yourself, if so, what was the nature of your injury: _____

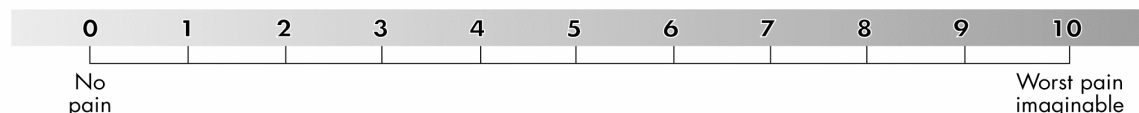
Please describe what your pain feels like: _____

Please check any of the following boxes that help describe your pain:

- Continuous Shooting Burning Sharp Tearing
 Off and On Dull Toothache Pulling Knife like

PLEASE RATE YOUR PAIN BELOW

0-10 Numeric Pain Intensity Scale



What makes your pain WORSE: _____

What makes your pain BETTER (check ALL that apply):

- Rest Sitting Lying down Standing Nothing at all
 OTHER: _____

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Do you have numbness in your arms or legs: No Yes
Do you get tingling in your arms or legs: No Yes
Do you have weakness in your arms or legs: No Yes
Since your pain began, have you lost TOTAL control of your bowel or bladder? _____

What medications have you taken BEFORE and stopped: _____

Please indicate if you have had the following treatment for your pain:

Epidural Steroid Injection Physical Therapy Chiropractor
 Acupuncture Trigger Point Injections OTHER: _____

Which has helped your pain: _____

Please indicate if you have had the following tests for your pain:

MRI CT Scan Electromyogram / EMG Bone Scan X-Rays

Which other doctors do you see: _____

Please indicate all illnesses and disorders for which you are being treated or followed by a doctor:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver disease/Hepatitis
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Underactive Thyroid	<input type="checkbox"/> Kidney Failure
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Overactive Thyroid	<input type="checkbox"/> Dialysis
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Urine Infections
<input type="checkbox"/> Blocked Carotid Artery	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Asthma	<input type="checkbox"/> Seizures
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Stroke
<input type="checkbox"/> Depression	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> HIV / AIDS

OTHER:

Please list all **SURGERY** you have had:

<input type="checkbox"/> Lumbar /Back	<input type="checkbox"/> Heart Bypass	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Neck	<input type="checkbox"/> Lung _____	<input type="checkbox"/> Caesarian Section
<input type="checkbox"/> Gallbladder Removal	<input type="checkbox"/> Aortic Aneurysm Repair	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Appendix Removal	<input type="checkbox"/> Carotid Artery Repair	<input type="checkbox"/> Brain
<input type="checkbox"/> Tonsil Removal	<input type="checkbox"/> Leg Artery Bypass	<input type="checkbox"/> Bowel Removal _____
<input type="checkbox"/> Bladder	<input type="checkbox"/> Kidney Stone	<input type="checkbox"/> Exploraton of Bowel
<input type="checkbox"/> Broken Bone _____	<input type="checkbox"/> Cataract	<input type="checkbox"/> Prostate

OTHER: _____

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Please list all your **MEDICATIONS** and doses:

DRUG	DOSE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all drug **ALLERGIES**: _____

Are you taking any **BLOOD THINNING MEDICATIONS**: Yes No

What is your current occupation: _____

Does it involve lifting or bending: _____

Are you currently out of work on disability: _____

Do you smoke, and how much: _____

Do you consume alcohol and how much: _____

Do you use recreational drugs: _____

Are your mother or father deceased, if so from what illness and at what age: _____

Do you have any brothers or sisters, please list their ages: _____

Has anyone in your immediate family had a similar medical problem as the one that has brought you here today: _____

Do you currently have any of these symptoms:

- Severe weight loss
- Seizure
- Very easy bruising
- Very high fever
- Stroke
- Excessive bleeding
- Night sweating
- Passing out
- Suicidal Thoughts
- Nausea / Vomiting
- Chest Pain
- Blurry vision
- Diarrhea
- Heart Palpitations
- Double vision
- Constipation
- Irregular Heartbeat
- Loss of hearing
- Bloody Urine
- Chronic cough
- Ringing in the ears
- Constant Urination
- Wheezing
- Painful Urination
- Bloody Sputum

Additional Information: