UF UNIVERSITY of FLORIDA

Pain Medicine Clinic

Please complete the attached questionnaire before your appointment. It is confidential and will be part of your medical record. It asks for information about your current problems and your past medical history. This form will give your doctor a better understanding of your problem, and will allow him or her to spend more time discussing treatment plans with you.

INITIAL VISIT PATIENT INFORMATION

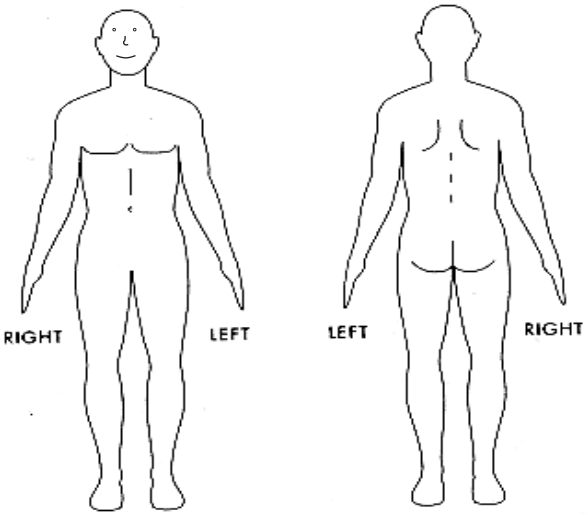
When you come for your first visit, **please bring this completed form** along with **any medical records, X-rays, CT or MRI scans, medication bottles** and other medical information related to your chronic pain problem.
Should you have any questions, please do not hesitate to contact us.

Name: _____ Phone #_____ Date of Birth _____

Primary Care Physician:

Name: _____ Phone # _____ Fax # _____
Address: _____

Front **Back**



What are your activity goals for your pain treatment?

1) _____
2) _____
3) _____

How long have you had chronic pain? month/year_____

Please describe events surrounding the onset of your pain. (i.e., date of injury, activities that made it worse?)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please shade in the areas where you feel pain.
Put an X on the area that hurts the most.

In the last year, how many emergency room visits have you had for pain? (circle) 0 1 2 3 5 – 10

WHICH WORDS DESCRIBE the QUALITY of your pain:

1.	Throbbing	5.	Cold freezing	8.	Shooting
2.	Cramping	6.	Hot-burning	9.	Stabbing
3.	Heavy/pressure	7.	Electric-shock	10.	Itching
4.	Tingling/pins & needles			11.	Numbness

Please circle all ACTIVITIES that MAKE YOUR PAIN WORSE: rest touch sitting standing bending lifting walking light exercise sex warm compresses cold compresses relaxation techniques Other:_____

Please circle all ACTIVITIES that MAKE YOUR PAIN BETTER: rest touch sitting standing bending lifting walking light exercise sex warm compresses cold compresses relaxation techniques Other:_____

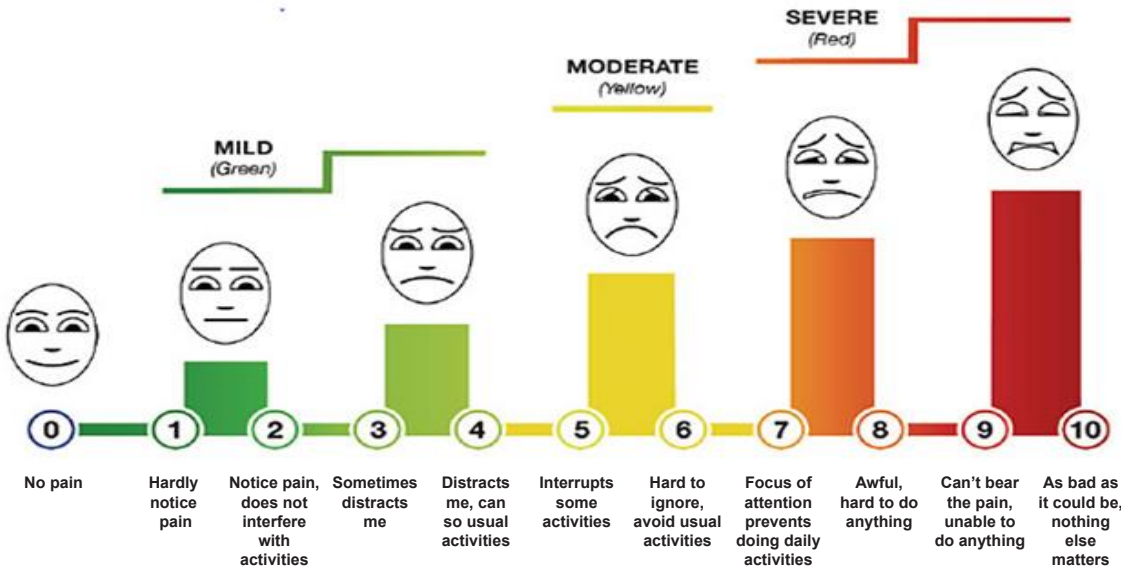
Please circle: RELIEF (%) YOU HAVE HAD IN THE LAST 24 HOURS from medications & treatments**:**

No Relief 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Complete Relief

WHEN YOU TAKE YOUR MEDICATION, how many HOURS OF RELIEF do you get?

_____ hours No help at all. I do not take pain medications

Does your pain affect your sleep? YES NO **Does your pain cause depression? YES NO**
Does your pain cause anxiety? YES NO



Please circle the number that indicates your **WORST PAIN LEVEL over the last week:**

No pain 0 1 2 3 4 5 6 7 8 9 10 **WORST** you can imagine

Please circle the number that indicates your **LEAST PAIN LEVEL over the last week:**

No pain 0 1 2 3 4 5 6 7 8 9 10 **WORST** you can imagine

Please circle the number that indicates your **AVERAGE PAIN LEVEL over the last week:**

No pain 0 1 2 3 4 5 6 7 8 9 10 **WORST** you can imagine

Please circle the number that indicates your **CURRENT PAIN LEVEL – RIGHT NOW:**

No pain 0 1 2 3 4 5 6 7 8 9 10 **WORST** you can imagine

Please help us understand **HOW PAIN HAS INTERFERED WITH your:**

A. General Activity
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **completely interferes**

B. **Mood**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **completely interferes**

C. **Walking Ability**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **completely interferes**

D. **Ability to perform tasks at home or at work:**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **completely interferes**

E. **Relations with other people**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **completely interferes**

F. **Sleep**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **completely interferes**

G. **Enjoyment of life**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **completely interferes**

Other Symptoms: PLEASE CIRCLE those you've had DURING THE PAST MONTH:

General:
- fever
- chills
- weight loss
- weight gain
- fatigue
- weakness
- sweating

Skin:
- rash
- itching

Head, Ears, Nose, Throat:
- headache
- hearing change
- ears ringing
- ear pain
- ear drainage
- nosebleeds
- congestion

Eyes:
- blurred vision
- double vision
- sensitivity to light
- eye pain
- eye drainage
- eye redness

Cardiovascular:
- chest pain
- rapid heartbeat
- irregular heartbeat
- lying down→ short of breath
- leg swelling

Respiratory:
- cough
- productive cough
- coughing blood
- short of breath w/ exertion
- wheezing

Gastrointestinal:
- heartburn
- nausea
- vomiting
- abdominal pain
- diarrhea
- constipation
- blood in stool
- black stool

Urinary:
- pain
- urgency
- frequency
- urinary incontinence
- blood in urine
- flank pain
- pelvic pain

Musculoskeletal:
- muscle aches
- low back pain
- neck pain
- joint pain
- falls

Bleeding / Allergic:
- bruise easily
- bleeding easily
- environmental allergies
- increased thirst

Neurologic:
- dizziness
- tremor
- change in sensation
- change in speech
- focal weakness
- changes alertness

Psych:
- depression
- suicidal thoughts
- hallucinations
- nervous / anxious
- irritability
- insomnia
- memory problems

Have you ever had (currently or in the past):

YES NO treatment for **mood, anxiety, and/or sleep disorders?**
YES NO **nightmares or flashbacks from prior traumatic experiences?**
YES NO **alcohol, illicit drug, or prescription medication misuse/addiction?**
YES NO problems with **compulsive behaviors such as gambling, eating disorder, etc.?**
YES NO **hospitalization for anxiety or depression?**
If yes, please explain:_____
_____

Pain Management Procedures That You've Had

	How many	Date(s) performed (Approximate)
___ Trigger Point Injections	_____	_____
___ Medial Branch Nerve Blocks	_____	_____
___ Radiofrequency Nerve Ablation or Rhizotomy	_____	_____
____Epidural Steroid Injection	_____	_____
____Caudal Steroid Injection	_____	_____
____Spinal Cord Stimulator	_____	_____
____Facet Joint Injection	_____	_____
____Sacroiliac Joint injection	_____	_____
____Stellate Ganglion Block	_____	_____
____Lumbar Sympathetic Block	_____	_____
___ Intercostal Nerve Block	_____	_____
___ Knee Genicular Nerve Block	_____	_____
___ Occipital Nerve Block	_____	_____
___ Botox Injection	_____	_____
___ Kyphoplasty/Vertebroplasty	_____	_____

How many physicians have been involved in the treatment of your pain? (Please circle)
0-3 4-5 6-10 11-15 16-20

How many emergency room visits have you had in the last year for pain? (Please circle)
0 1 2 3 5 - 10

Have you ever been discharged from a pain clinic for any reason? YES NO
If_ yes, please explain**:**_____
_____

Past Medications That You've Tried: please indicate **Dosage, Benefits & Side Effects**:

Medication	Dose and Frequency	Benefits?	Side effects?
Anti-Inflammatory (NSAID's)			
Ibuprofen (Motrin, Advil)			
Naproxen (Aleve, Naprosyn, Anaprox)			
Meloxicam (Mobic)			
Celecoxib (Celebrex)			
Toradol (Ketorolac)			
Narcotic Pain Medications			
Propoxyphene (Darvocet)			
Ultram (Tramadol)			
Codeine (Tylenol #3)			
Meperidine (Demerol)			
Hydromorphone (Dilaudid)			
Fentanyl (Duragesic) Patch			
Morphine (MS Contin, Kadian, Avinza)			
Hydrocodone (Lorcet, Lortab, Vicodin)			
Methadone (Dolophine)			
Oxycodone ER (Oxycontin)			
Oxycodone (Percocet, Roxycodone)			
Butorphanol (Stadol)			
Pentazocine (Talwin)			
Buprenorphine (Suboxone, Subutex)			
"Membrane Stabilizers"			
Gabapentin (Neurontin)			
Pregabalin (Lyrica)			
Valproate (Depokote)			
Carbamazepine (Tegretol)			
Topiramate (Topamax)			
Lamotrigine (Lamictal)			
"Anti-Depressants"			
Amitriptyline (Elavil)			
Imipramine (Tofranil)			
Desipramine (Norpramin)			
Doxepin (Sinequan)			
Nortriptyline (Pamelor)			
Milnacipran (Savella)			
Duloxetine (Cymbalta)			
Venlafaxine (Effexor)			
Desvenlafaxine (Pristiq)			
Prozac (Fluoxetine)			
Paroxetine (Paxil)			
Trazodone (Desyrel)			
Bupropion (Wellbutrin)			
"Local" or "Topical" (applied to skin)			
Diclofenac (Voltaren) Gel			
Lidoderm Patch			
Flector Patch			
Capsacian			
Salonpas, Icy Hot, Bengay, or Tiger Balm			

Past Medications That You've Tried: please indicate **Dosage, Benefits & Side Effects**:

Benzodiazepines ("Minor Tranquilizers")

Diazepam (Valium)	_____	_____
Clonazepam (Klonopin)	_____	_____
Alprazolam (Xanax)	_____	_____
Lorazepam (Ativan)	_____	_____

Muscle Relaxants

Baclofen (Lioresal)	_____	_____
Carisoprodol (Soma)	_____	_____
Cyclobenzaprine (Flexeril)	_____	_____
Methocarbamol (Robaxin)	_____	_____
Metazalone (Skelaxin)	_____	_____
Tizanidine (Zanaflex)	_____	_____

Past Medical History

_____
_____
_____

Past Surgical History

_____
_____
_____

Allergies: _____
_____

Are you allergic to Iodine or IV contrast dye? YES NO

FAMILY HISTORY:

Please list family members' illnesses (cancer, diabetes, psych, substance use, etc.)_____
_____

YES NO Any family members have / had **alcohol, illicit drug, or prescription med misuse/addiction?**

YES NO Problems with **compulsive behaviors** such as **gambling, eating disorder, etc.?**

YES NO Does **anyone in your household take prescription pain medications?**

YES NO Does **anyone in your household use illicit drugs?**

SOCIAL HISTORY

Marital status: Single Married Separated Divorced Widowed

Who lives at home with you?_____

Family support: STRONG AVERAGE MINIMAL NONE

Your **sources of enjoyment &/or support** (family, friends, hobbies)**?**_____

What are your **sources of stress** (family, finances, etc.)? _____

Employment:

YES NO **Are you currently employed?** Occupation_____ #Hrs/day _____ # Days/week_____

IF NO: When did you last work?_____ What was your **most recent job**? _____

YES NO Are you currently receiving **disability benefits?** Since when?_____

YES NO Are you involved with **Worker's Compensation? YES NO** Is there **litigation pending**? **YES NO**

Spirituality and/or Religion: an important role in your life? _____

_____

Education: please circle the highest level of education you have completed

Grade School High School Junior College Trade School

Some College Graduated College Graduate / Professional School

SUBSTANCE USE

YES NO **Do you smoke cigarettes?** How many packs per day? _____ How many years? _____

If you are a former smoker when did you quit?_____How many packs per day? _____ How many years? _____

YES NO **Do you use alcohol?** About how often?_____ For how many years?_____

YES NO **Do you use illegal drugs?** About how often?_____ For how many years?_____

YES NO **Have you ever had a problem w/ alcohol, illicit drugs, or prescription meds?** If yes, please explain:

_____

_____

_____

HAVE YOU EVER:

YES NO **had prescription pain medications lost or stolen?**

YES NO **shared your prescription pain medications with others** (family, friends)**?**

YES NO **taken more prescription pain medication than prescribed, or run out early?**

YES NO **taken prescription pain medications to relieve non-pain symptoms** (anxiety, sleep)**?**

YES NO **consumed prescription pain meds that were not prescribed to you** (from family, friend)**?**

YES NO **altered a prescription pain pill for enhanced effect** (such as crushing a time-release tab)**?**

YES NO **been in a treatment program for alcohol or drug abuse?**

YES NO **attended a 12 step meeting such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)?**

YES NO **had a DUI or been arrested for using or selling illicit drugs?**

YES NO **had a drug overdose?**

YES NO **Had someone express concern about your overuse of prescription pain meds, drugs or alcohol**?

YES NO **been discharged from a pain clinic for any reason? If yes, please explain:**

_____

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE, PLEASE EXPLAIN: _____

_____

_____

_____

Name of last physician or clinic where you received treatment for chronic pain: _____

Why are you no longer being treated there? _____

_____

THANK YOU FOR COMPLETING THIS FORM.

WE LOOK FORWARD TO THE OPPORTUNITY TO PARTICIPATE IN YOUR CARE.