Pain Patient Questionnaire

Please fill out as completely as possible, print and take with you to your Pain Center visit.
All answers will be confidential. If you have questions, please call 954-430-1700.

Memorial Same Day Surgery Centers

Date:

Patient's Full Name:

Home Telephone:

Work Telephone:

Patient's Age:

Date of Birth:

Sex: ☐ Male ☐ Female

Primary Physician:

Primary Physician's Telephone:

Referring Physician:

Referring Physician's Telephone:

Marital Status: ☐ Single ☐ Married

Highest Education Level Attained:

Height:

Weight:

Do you smoke? ☐ Yes ☐ No

If yes, how many packs per day?

How many years have you smoked?

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, how often?

Do you use any recreational drugs? ☐ Yes ☐ No

If yes, describe:

Employed? ☐ Yes ☐ No

Occupation:

If applicable, would you return to work if you had no pain problem? ☐ Yes ☐ No

Is your pain the result of an accident? ☐ Yes ☐ No

How often do you have pain?

Does your pain affect your sleep? ☐ Yes ☐ No

Falling asleep? ☐ Yes ☐ No

Are you awakened by pain in the middle of the night? ☐ Yes ☐ No

Mark any symptoms and adjectives associated with your pain:

☐ Numbness
☐ Weakness
☐ Urinary incontinence
☐ Redness
☐ Swelling
☐ Tenderness of affected area
☐ Cool, pale skin
☐ Burning pain when touched lightly
☐ Mild
☐ Shooting
☐ Prevents family duties
☐ Moderate
☐ Stabbing
☐ Prevents social duties
☐ Strong
☐ Tingling
☐ Affects appetite
☐ Dull
☐ Cramping
☐ Affects bowels
☐ Aching
☐ Squeezing
☐ Throbbing

During the past month, is your pain worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ No Typical Pattern

What makes your pain better?

What makes your pain worse?

Have you ever had psychiatric or psychological evaluation treatment for the problems including your current pain? ☐ Yes ☐ No

Have you had any CT scan or MRI for your current pain problem? ☐ Yes ☐ No

What is the main complaint for which you are seeking treatment at the Pain Clinic?

How long have you had this current pain problem you are experiencing?

How did your current pain start?

Please check all the treatments you have tried for your pain from the list below, and complete the appropriate columns at the right.

Treatment	Dates	Results
☐ Hospital bed rest		
☐ Traction		
☐ Surgery		
☐ Acupuncture		
☐ Nerve block		
☐ TENS(electrical stimulator)		
☐ Physical therapy		
☐ Exercise		
☐ Chiropractor		
☐ Other (specify)		

Have any other health care professionals and/or specialists been involved in the evaluation and treatment of your current pain? ☐ Yes ☐ No
Please be specific:

Please list all of the medications you have tried for your current pain problem.

List ALL medications you are currently taking.

Do you have any drug allergies? ☐ Yes ☐ No If yes, please list:

Are you allergic to seafood? ☐ Yes ☐ No

Have you ever had surgery? ☐ Yes ☐ No If yes, please list:

Aside from your pain problem, how is your general health? ☐ Excellent ☐ Minor health problems only ☐ Major health problems

Have you had any of the following health problems? (Check all that apply)

☐ High blood pressure
☐ Diabetes or high blood sugar
☐ Angina or chest pain
☐ Kidney disease
☐ Heart attack
☐ Transient ischemic attack (TIA) or stroke
☐ Asthma or wheezing
☐ Liver disease, hepatitis, cirrhosis
☐ Chronic Cough
☐ Seizure or epilepsy
☐ Bleeding problems
☐ Cancer
☐ Arthritis
☐ Depression/Mania
☐ Other (Specify): ______