Name:
DOB:
Age:
Date:

WEST TENNESSEE BONE & JOINT

PAIN MANAGEMENT MEDICAL HISTORY

(Please Print)

Referring Physician: _____

Primary Care Physician: _____

Current occupation: _____

Height: _____ Weight: _____

Pregnancy Status:
- ☐ Currently Pregnant
- ☐ Not applicable
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ Post Menopausal
- ☐ Birth Control
- ☐ Sterile
- ☐ No Current Preventative Measures

Onset of Symptoms:

Where is your worst area of pain located? _____

When did this pain begin? _____

What caused your current pain or injury? _____

Other Providers you have seen to treat your pain:

☐ Acupuncturist ☐ Neurosurgeon ☐ Orthopedic Surgeon ☐ Pain Physician ☐ Physical Therapist ☐ Neurologist
☐ Primary Care Provider ☐ Psychiatrist/Psychologist ☐ Rheumatologist ☐ Other

Names of each: _____

Pain Treatment History - Mark the following pain treatments you have undergone PRIOR to today's visit:

Treatment	No Relief	Moderate Relief	Excellent Relief
☐ Spine Surgery	☐	☐	☐
☐ Spinal Cord Stimulator	☐	☐	☐
☐ Intrathecal Pain Pump	☐	☐	☐
☐ Epidural Type Injections	☐	☐	☐
☐ Facet Type Injections	☐	☐	☐
☐ SI Joint Treatments	☐	☐	☐
☐ Trigger Point Injections	☐	☐	☐
☐ Physical Therapy, Last Date Attended: _____	☐	☐	☐
☐ Chiropractic Therapy	☐	☐	☐
☐ Massage Therapy	☐	☐	☐
☐ Acupuncture	☐	☐	☐
☐ Home Exercise	☐	☐	☐
☐ Braces	☐	☐	☐
☐ NSAIDs	☐	☐	☐
☐ Acetaminophen	☐	☐	☐
☐ Aspirin	☐	☐	☐
☐ Topical Creams or patches	☐	☐	☐
☐ Muscle Relaxants	☐	☐	☐
☐ Nerve Membrane Stabilizers	☐	☐	☐
☐ Anti-depressants	☐	☐	☐
☐ Opioids	☐	☐	☐
☐ Other, Please list: _____	☐	☐	☐

Past Medical History - Mark all conditions/diseases that you have been diagnosed with:

- ☐ Diabetes ☐ Type I ☐ Type II
- ☐ Bleeding Disorders
- ☐ Chronic need/use of blood thinners
- ☐ Cancer History
- ☐ Blood/bone cancer history
- ☐ Multiple sclerosis
- ☐ Seizures
- ☐ Stroke/TIAs
- ☐ Brain/closed head injury
- ☐ Headaches/migraines
- ☐ Peripheral neuropathy
- ☐ Peripheral nerve injury
- ☐ Carpal Tunnel Syndrome
- ☐ Spinal Cord Injury
- ☐ Diabetic neuropathy
- ☐ CRPS/RSD Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy
- ☐ Phantom limb pain
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Alcohol/drug/dependency/treatment
- ☐ Anxiety disorder
- ☐ PTSD Post Traumatic Stress Disorder
- ☐ Mental/Developmental Delay
- ☐ Dementia/Alzheimers
- ☐ Fibromyalgia
- ☐ Rheumatologic/RA/Osteoarthritis/Lupus/Raynauds
- ☐ Degenerative Joint Disease
- ☐ Osteopenia/Osteoporosis
- ☐ Vertebral compression fracture
- ☐ Hip/wrist/arm/leg fracture
- ☐ Glaucoma
- ☐ Thyroid Disorder
- ☐ Asthma/COPD
- ☐ Tuberculosis
- ☐ Atherosclerotic/Coronary Heart Disease
- ☐ Heart Attack/MI
- ☐ Hypertension
- ☐ Pacemaker/defibrillator
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ Cirrhosis
- ☐ HIV/AIDS
- ☐ Hiatal hernia
- ☐ GERD
- ☐ Gastroparesis
- ☐ Chronic constipation
- ☐ Bowel incontinence
- ☐ Colostomy/ileostomy
- ☐ Chronic diarrhea
- ☐ Diverticulitis/colitis
- ☐ Kidney disease/insufficiency
- ☐ Kidney failure/End stage renal disease
- ☐ Hemodialysis
- ☐ Kidney stone/nephrolithiasis
- ☐ AV fistula
- ☐ Recurrent kidney/bladder infections
- ☐ Prostate hypertrophy
- ☐ Prostate cancer
- ☐ Urinary incontinence

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Surgical History:

	Type:	Date:
☐ Brain		
☐ Spine		
☐ Joint		
☐ Fracture repair/fixation		
☐ Heart surgery/stenting		
☐ Vascular surgery/stenting		
☐ Lung		
☐ Liver/gallbladder		
☐ Bowel/colon		
☐ Appendix		
☐ Kidney/prostate/bladder		
☐ Thyroid		
☐ Eye/ear/throat		
☐ Hysterectomy/oophorectomy/ovarian		
☐ Other:		

Social History:

Never smoker:	☐		
Former Smoker:**	☐	**Date Started:	
Current some day smoker:**	☐	**Date Stopped:	
Current everyday smoker:**	☐	**Packs Per Day:	

Do you drink alcohol? ☐ Yes ☐ No
☐ Social Alcohol Use ☐ History of Alcoholism
Marijuana Use: ☐ Never ☐ Current User
☐ Former User ☐ Medical Marijuana Card Holder

☐ I Have Abused Narcotic or Prescription Medications. List: _____
☐ History of Alcohol or Drug Abuse.

Family History:

Has anyone in your family had: (check all that apply)

	Father	Mother	Sibling	Child	Other
High Blood Pressure					
Heart Disease					
Diabetes					
Bleeding Problems					
Lung Disease					
Cancer					

what type? _____

☐ None

Review of Systems - Mark all of the following that you **CURRENTLY** suffer from:

Constitutional:
☐ Chronic cough
☐ Fever
☐ Chills
☐ Night Sweats
☐ Weight Loss
☐ Weight Gain
☐ Insomnia

Eyes:
☐ Change in vision/acuity
☐ Eye Pain
☐ Glaucoma

Ears/Nose:
☐ Recurrent Nose Bleeds
☐ Difficulty Hearing

Skin:
☐ Skin infections
☐ Changes in skin color

Respiratory:
☐ Shortness of Breath
☐ Wheezing
☐ Sleep apnea
☐ Home oxygen/Cpap

Cardiovascular:
☐ Chest Pain
☐ Palpitations
☐ Pacemaker/defibrillator
☐ Swelling in feet/edema

Gastrointestinal:
☐ Constipation
☐ Diarrhea
☐ Nausea/Vomiting
☐ Gastritis
☐ Reflux/GERD/hiatal hernia
☐ Diverticulitis/colitis
☐ Blood in stools

Genitourinary:
☐ Loss of bladder control
☐ Difficulty urinating
☐ Recurrent infections/UTIs
☐ Blood in urine

Musculoskeletal
☐ Neck Pain
☐ Mid scapular/upper back pain
☐ Low back pain
☐ Shoulder pain
☐ Arm/elbow pain
☐ Wrist/hand pain
☐ SI joint pain
☐ Hip pain
☐ Knee pain
☐ Ankle/foot pain

Neurological:
☐ Vertigo
☐ Dizziness
☐ Instability when walking
☐ Leg weakness
☐ Arm/hand weakness
☐ Arm/hand numbness
☐ Leg/foot numbness
☐ Headaches

Psychiatric:
☐ Depression
☐ Suicidal thoughts/planning
☐ Bipolar disorder
☐ Anxiety/increased worrying

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Patient or Responsible Party Signature: _____ **Date:** _____