UNIVERSITY of ROCHESTER MEDICAL CENTER

Patient Questionnaire

Patient Identification Sticker

Pain Treatment Center

PLEASE FILL OUT AND BRING WITH YOU TO YOUR FIRST APPOINTMENT. BE SURE TO INCLUDE A LIST ALL YOUR MEDICATIONS AND ANY X-RAY/MRI IMAGING RELATED TO YOUR PAIN.

When did your pain begin: Month_____ Year_____

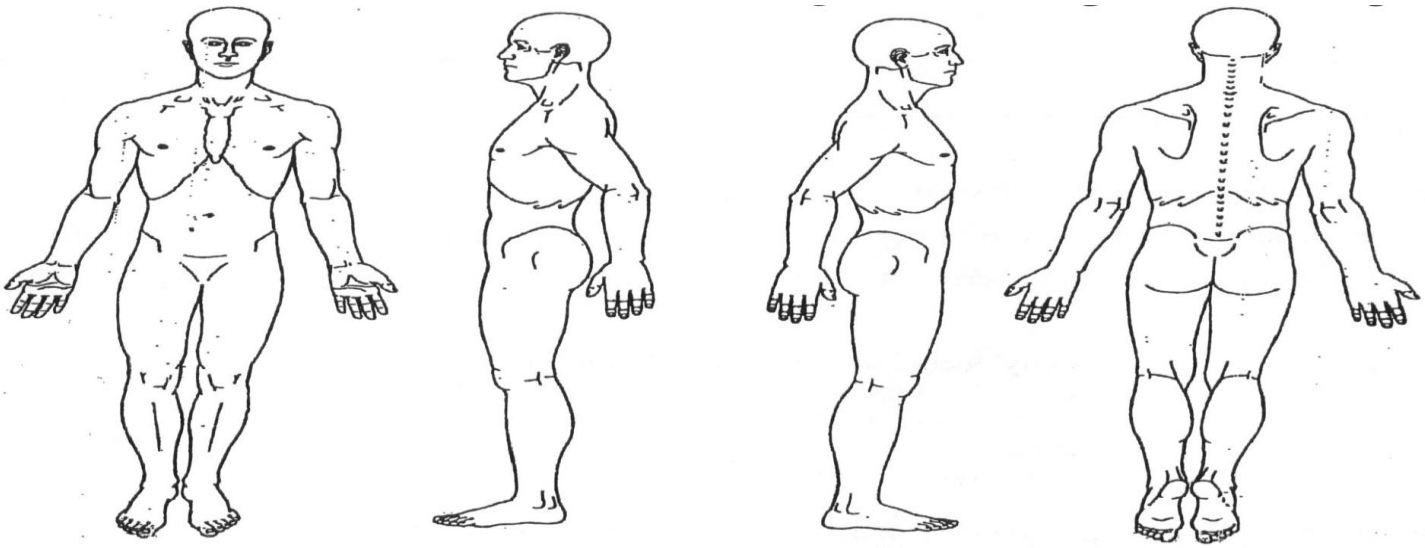
Describe how your pain started (ex. Accident, lifting, surgery, following an illness):

The Pain (Please Check One):	
☐	Only occurs under certain circumstances
☐	Is rarely present
☐	Is usually present
☐	Is always present

Since the beginning of the present problem, has the intensity of the pain (Please Check One)	
☐	Been variable
☐	Remained the same
☐	Decreased
☐	Increased
☐	Unknown

Please indicate on a scale of 1 - 10 intensity of your pain. 0 being NO PAIN, 10 being VERY SEVERE PAIN	
	Your pain right now
	The average intensity of your pain this week
	Your pain at its worst in the last week
	Your pain at its least in the last week

On the picture below - mark the area of your pain



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Yes	No	How would you describe your pain?
☐	☐	Sharp
☐	☐	Dull
☐	☐	Aching
☐	☐	Burning
☐	☐	Throbbing
☐	☐	Shooting
☐	☐	Stabbing
☐	☐	Lighting Shock
☐	☐	Pressure
☐	☐	Cutting
☐	☐	Cramping
☐	☐	Radiating
☐	☐	Soreness
☐	☐	Terrifying
☐	☐	Tight
☐	☐	Hot
☐	☐	Tingling
☐	☐	Other

Yes	No	Alleviating Factors
☐	☐	Walking
☐	☐	Sitting
☐	☐	Standing
☐	☐	Lying
☐	☐	Medications
☐	☐	Prayer
☐	☐	Socializing
☐	☐	Heat
☐	☐	TENS Unit
☐	☐	Exercise
☐	☐	Eating
☐	☐	Cold
☐	☐	Recreation/distracting activities
☐	☐	Relaxation exercises
☐	☐	Other

Yes	No	Aggrevating Factors
☐	☐	Walking
☐	☐	Sitting
☐	☐	Standing
☐	☐	Bending
☐	☐	Lifting
☐	☐	Twisting
☐	☐	Lying Down
☐	☐	Stairs
☐	☐	Sexual Activity
☐	☐	Changes in weather
☐	☐	Anything touching skin
☐	☐	Use of arms
☐	☐	Use of legs
☐	☐	Eating
☐	☐	Bright lights
☐	☐	Loud noises
☐	☐	Stress
☐	☐	Bowel movement
☐	☐	Driving
☐	☐	Exercise
☐	☐	Other

Pain Treatment Center

What other specialists/treatments have you seen or done for your pain? Check all that apply.

☐	Acupuncturist	☐	Psychologist
☐	Anesthesiologist	☐	Radiologist
☐	Biofeedback	☐	Reflexology
☐	Cardiologist	☐	Relaxation Training
☐	Chiropractor	☐	Social Worker (MSW)
☐	Cleryman	☐	Surgeon
☐	Dentist	☐	Urologist
☐	Dermatologist	☐	Other
☐	ENT Specialist	☐	
☐	Endrocrinologist	☐	
☐	Faith Healer	☐	**Treatments**
☐	General/Family Practitioner	☐	Anit-inflamatory
☐	Herbal Remedies	☐	Epidural Injection
☐	Hypnotist	☐	Facet Joint Injections
☐	Internist	☐	Muscle Relaxant
☐	Massage Therapist	☐	Narcotic Pain Medication
☐	Neurologist	☐	Pool Therapy
☐	Ophthalmologist	☐	SI Injections
☐	Pediatrician	☐	Spine Surgery
☐	Physical Therapist	☐	Trigger Poing Injection
☐	Plastic Surgeon	☐	TENS Unit
☐	Psychiartrist	☐	Other

Have any of the above helped relieve some or all of your pain? If so, for how long? _____

Have you ever been seen by a Pain Clinic/specialist before? Y N

If so, where? _____

What x-rays or tests have you had done? Check all that apply

☐	MRI
☐	Nerve Conduction Study
☐	CT Scan
☐	Blood Work
☐	Bone Scan

Pain Treatment Center

Medications

Current Pain Medications				
Medication	Dosage	How Many/Da	Reason for Taking	Who Prescribes

Current Other Medications (Include over-the-counter medications)				
Medication	Dosage	How Many/Da	Reason for Taking	Who Prescribes

Allergies

Medications (List with Reaction)
Latex Allergies (If yes describe reaction) - Y N
Contrast Allergies (If yes describe reaction) - Y N

Pain Treatment Center

Yes	No	Past Medical History
☐	☐	Diabetes, high blood sugar
☐	☐	Hypertension, high blood pressure
☐	☐	Hyperlipidemia, high cholesterol or triglyceride
☐	☐	Cardiovascular (heart or blood vessel) disease
☐	☐	Stroke or TIA
☐	☐	Thyroid disease
☐	☐	Parathyroid disease or high blood calcium
☐	☐	Pituitary disease
☐	☐	Adrenal disease
☐	☐	Gonadal disease
☐	☐	Other (please list)

Please List Prior Surgeries

Yes	No	Family History
☐	☐	Diabetes, high blood sugar
☐	☐	Hypertension, high blood pressure
☐	☐	Hyperlipidemia, high cholesterol or triglyceride
☐	☐	Cardiovascular (heart or blood vessel) disease
☐	☐	Thyroid disease
☐	☐	Other hormonal diseases
☐	☐	Drug Use (Past or Present)
☐	☐	Alcohol Use (Past or Present)
☐	☐	Other (please list)

Personal History	
What is your marital status?	
☐	Single
☐	Married
☐	Seperated
☐	Divorced
☐	Widowed
With whom do you live?	
Number of children:	
Ages	

Pain Treatment Center

Yes	No	Work History
☐	☐	Are you currently working?
		If yes, your occupation? ***How many hours per wk.***
		If no, are you applying for compensation?
☐	☐	***Disability?***
☐	☐	Are you involved in legal action regarding your pain?
☐	☐	Would you like to return to the work force?

Yes	No	Social History
☐	☐	Do you or have you smoke/d?
		How long?_____ yrs. How much?_____ packs.
☐	☐	Do you or drink alcohol? How much?
☐	☐	Have you used alcohol in the past?
☐	☐	Do you use recreational drugs?
		Which?
☐	☐	Have you used drugs in the past?
☐	☐	Do you engage in hazardous activities?
		What?

Pain Treatment Center

Yes	No	Constitutional
☐	☐	Poor general health recently
☐	☐	Recent weight change, loss of appetite
☐	☐	Fever, chills, profuse sweating
☐	☐	Fatigue, lethargy, malaise
		Eyes
☐	☐	Recent eye disease, injury or surgery
☐	☐	Blurred vision, double vision, loss of vision
☐	☐	Pain in the eyes
☐	☐	Eye examination within the last year
		Ears, Nose, Mouth, Throat
☐	☐	Hearing loss or ringing in the ears
☐	☐	Ear pain or discharge
☐	☐	Chronic or recurring sinus problems
☐	☐	Chronic or recurring sores in the nose/mouth
☐	☐	Chronic or recurring dental problems
☐	☐	Chronic or recurring sore throat
		Cardiovascular
☐	☐	Chest pain
☐	☐	Rapid or irregular heartbeat, palpitations
☐	☐	Sudden loss of consciousness, fainting
☐	☐	Shortness of breath with exertion
☐	☐	Swelling of the feet, ankles or hands
		Respiratory
☐	☐	Chronic coughing
☐	☐	Coughing up blood
☐	☐	Chronic wheezing, asthma
☐	☐	Chronic shortness of breath
		Gastrointestinal
☐	☐	Recurring nausea and vomiting, vomiting blood
☐	☐	Abdominal pain
☐	☐	Chronic or recurring diarrhea or constipation
☐	☐	Bloody bowel movements
☐	☐	Jaundice, liver disease
		Genitourinary
☐	☐	Frequent or painful urination
☐	☐	Blood in the urine
☐	☐	Urinary incontinence
☐	☐	Loss of sexual desire or sexual dysfunction
☐	☐	Irregular or painful menstrual periods

Yes	No	Musculoskeletal
☐	☐	Joint pain, stiffness or swelling
☐	☐	Muscle pain, weakness or cramping
☐	☐	Limitation of motion, difficulty walking
☐	☐	Chronic neck or back pain
☐	☐	Chronic foot pain or deformity
		Skin and Breasts
☐	☐	Chronic or recurring rashes or sores
☐	☐	Suspicious moles or skin lesions
☐	☐	Hair loss, change in nails
☐	☐	Breast pain, breast lump or nipple discharge
		Neurologic
☐	☐	Frequent or recurring headaches
☐	☐	Dizziness, lightheadedness
☐	☐	Seizures or convulsions
☐	☐	Loss of sensation or muscle strength
☐	☐	Stroke or head injury
☐	☐	Memory loss, confusion
☐	☐	Tremor
		Psychiatric
☐	☐	Nervousness or anxiety
☐	☐	Chronic depression
☐	☐	Inability to concentrate
☐	☐	Sleep problems
		Endocrine
☐	☐	Excessive thirst or urination
☐	☐	Heat or cold intolerance
☐	☐	Unexplained change in skin pigmentation
☐	☐	Change in hat or ring size
☐	☐	Loss of height
☐	☐	Unexplained bone fractures
		Hematologic / Lymphatic
☐	☐	Recurring nosebleeds, bleeding gums, bruising
☐	☐	Chronic anemia, recent transfusion
☐	☐	Swollen lymph nodes
☐	☐	Recurring infections
		Allergic / Immunologic
☐	☐	Hay fever
☐	☐	Recurring hives
☐	☐	History of HIV or AIDS

Doctor to complete below section

The above document has been reviewed with the patient.

Healthcare Provider Signature Date