CRANMORE HEALTH PARTNERS
Primary, Pain, and Urgent Care

Pain Management Clinic Medical History Form

Patient's Name: _____ Date of Birth: _____

Today's Date: _____ Patient's Age: _____ (circle) Right Handed Left Handed

Chief Complaint (why are you here today): _____

_____

History of Present Illness (what happened and when?): _____

_____

Past Medical History (any current or past medical problems, accidents or injuries) (circle):

Diabetes	High Blood Pressure	Ulcers
Cancer	Stroke	Heart Disease
Bleeding Problems	Seizure	Kidney Problems
COPD/Emphysema	Arthritis	Headaches
High Cholesterol	Asthma	Heart Failure

Other: _____

_____

Past Surgical History (Please list all past surgeries/operations):

Type of Surgery	Date	Type of Surgery	Date

Family History (Please tell us about the health of your immediate family):

	Father	Mother	Sister	Brother	Children	Other
Age at Death						
Cause of Death						
Heart Disease/Stroke						
High Blood Pressure						
High Cholesterol						
Diabetes						
Cancer (type)						
Epilepsy/Seizures						
Asthma/COPD						
Blood Disease						
Osteoarthritis						
Other:						

Social History (do you now or have you in the past):

Marital Status:	Single	Significant Other Married Divorced Widowed	
Living Situation:	Alone	Spouse/Significant Other Children/Family Other	
Do you have children?	Yes / No	If yes, how many?	
Females: Are you Pregnant?	Yes / No	Hysterectomy Menopause Tubal Ligation	
Education (highest level):	9 10 11 12 GED Some College Associates Bachelors Masters		
Are you working?	Yes / No	If yes, occupation?	
Are you disabled?	Yes / No	If yes, reason?	
Tobacco Use:	Yes / No	Cigarette Cigars Chew	Per Day:
If no, have you ever?	Yes / No	Cigarette Cigars Chew	Per Day:
Do you drink alcohol?	Yes / No	Beer Wine Liquor	Per Day:
Do you drink caffeine?	Yes / No	Soda Coffee Tea	Per Day:
Do you exercise?	Yes / No	Type?	Per Week:
Do you wear your seat belt?	Yes / No	If yes, percent of time:	
Any present illicit drug use?	Yes / No	Type:	
Any past illicit drug use?	Yes / No	Type:	
Do you have Advance Directives in place?	Living Will Durable Power of Attorney Health Care Proxy Advanced Directives		

Allergies:

Medication(s)	Reaction	Allergen	Reaction

Medication List:

Name	Dosage	Frequency

List medications **TRIED** for pain and their effectiveness:

Medication	Effect	Medication	Effect

What types of treatments have you tried and were they effective? (i.e.: Physical Therapy, Chiropractor, Acupuncture, etc.)

Treatment	Effect	Treatment	Effect

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Pain Management Review of Systems

Name: _____ Date of Birth: _____

Do you have any of the following? (Please check anything that applies)

CONSTITUTIONAL

□ Body Aches
□ Chills
□ Cold Intolerance
□ Daytime Naps
□ Daytime Sleepiness
□ Decreased Appetite
□ Difficulty Sleeping
□ Excessive Sweating
□ Falls Asleep During the Day
□ Fatigue
□ Fever
□ Food Intolerance
□ Frequent Falls
□ Headache
□ Heat Intolerance
□ Hot Flashes
□ Increased Appetite
□ Recent Infection
□ Irritability
□ Lack of Energy
□ Maintaining Hydration
□ Feels Ill
□ Night Sweats
□ Overweight/Underweight
□ Poor Appetite
□ Recent Trauma/Injury
□ Restlessness
□ Snoring
□ Stops Breathing During Sleep
□ Transfusions
□ Using CPAP or BiPAP
□Weakness

EYES

□ Blind spots
□ Blurry Vision
□ Bulging Eyes
□ Change in Vision
□ Decreased Night Vision
□ Double Vision
□ Discharge
□ Dry Eyes
□ Floaters
□ Glasses/Contacts
□ Irritation
□ Itchy Eyes
□ Loss of Peripheral Vision
□ Loss of Vision
□ Pain
□ Puffy eyes
□ Redness
□ Seeing Flashes
□ Sensitivity to Light
□ Spots in Vision
□ Tunnel Vision
□ Watery Eyes

HENMT

□ Dental Pain
□ Difficulty Swallowing
□ Ear Pain
□ Facial Pain
□ Hearing Loss
□ Hearing Abnormal
□ Hoarseness
□ Jaw Pain
□ Neck Lump/Swelling
□ Neck Pain
□ Nosebleed
□ Ringing in Ears
□ Sinus Pain
□ Sneezing/Sniffling
□ Sore Throat
□ Vertigo/Spinning Sensation
□ Pain With Swallowing

CARDIOVASCULAR

□ Bluish Discoloration of Hands/Feet
□ Chest Pain
□ Chest Pain at Rest
□ Chest Pain with Activity
□ Cramping
□ Cramping With Exercise
□ Excessive Sweating
□ Fainting
□ Fast Heart Rate
□ Foot Swelling
□ Generalized Swelling
□ Irregular Heart Rhythm
□ Leg Pain With Activity
□ Leg Sores
□ Leg Swelling
□ Lightheadedness
□ Palpitations
□ Radiating Jaw, Neck, or Arm Pain
□ Rapid, Pounding, or Irregular Heart Beat
□ Shortness of Breath
□ Shortness of Breath with Activity
□ Shortness of Breath when Lying Down
□ Shortness of Breath Causing Sudden Awakening
□ Slow Heart Rate

RESPIRATORY

□ Chest Congestion
□ Cough
□ Coughing Up Blood
□ Difficulty Breathing
□ Loud or Labored Breathing
□ Pain on Inspiration
□ Pain With Cough
□ Recent Infection(s)
□ Shortness of Breath
□ Shortness of Breath at Night
□ Shortness of Breath Walking
□ Shortness of Breath With Activity
□ Shortness of Breath With Stairs
□ Shortness of Breath When Lying Down
□ Snoring
□ Wheezing

GASTROINTESTINAL

□ Abdominal Pain
□ Black, Tarry Stools
□ Bloating
□ Bright, Red Blood in Stools
□ Change in Bowel Habits
□ Change in Stools
□ Constant Urge to Pass Stool
□ Constipation
□ Cramping
□ Diarrhea
□ Feeling Full Early
□ Flank Pain
□ Heartburn
□ Incontinence of Stools
□ Indigestion
□ Loose Stools
□ Nausea
□ Rectal Bleeding
□ Suprapubic Pain
□ Vomiting
□ Vomiting Blood

GENITOURINARY

□ Abnormal Periods

- □ Abnormal Vaginal Bleeding
- □ Change in Bladder Habits
- □ Change in Libido
- □ Decreases Urination
- □ Difficulty Getting Pregnant
- □ Difficulty Urinating
- □ Frequent Nightitme Urination
- □ Pelvic Pain
- □ Postmenopausal
- □ Side Pain
- □ Urinary Frequency
- □ Urinary Hesitancy
- □ Urinary Incontinence
- □ Urinary Retention
- □ Urinary Urgency

MUSCULOSKELETAL

- □ Abnormal Walking
- □ Ankle Pain
- □ Arm Pain
- □ Artificial Joints
- □ Back Pain
- □ Body Aches
- □ Cold Extremities
- □ Decreased Muscle Mass
- □ Deformity
- □ Double Jointed
- □ Foot Pain
- □ Heel Pain
- □ Hip Pain
- □ Jaw Pain
- □ Joint Pain
- □ Joint Stiffness
- □ Joint Swelling
- □ Knee Pain
- □ Leg Pain
- □ Leg Swelling
- □ Limited Joint Movement
- □ Loss of Height
- □ Muscle Aches/Pain
- □ Muscle Cramps
- □ Muscle Weakness
- □ Muscle Spasms
- □ Neck Pain
- □ Numbness
- □ Radiating Pain Into Limb
- □ Recurrent Sprains
- □ Shoulder Pain
- □ Sternal/Rib Pain
- □ Tingling

INTEGUMENTARY

- □ Birthmarks
- □ Bleeding Lesions
- □ Change in Hair
- □ Change in Skin Color
- □ Changing Lesions
- □ Dry Skin
- □ Hair Loss
- □ Hives
- □ Implants
- □ Insect Bites
- □ Itching
- □ Intrathecal Pump
- □ Lesions
- □ Lumps
- □ Metal in Body
- □ Moles
- □ Nail Changes
- □ New lesions
- □ Non-Healing Lesions
- □ Piercings
- □ Rash
- □ Redness
- □ Sensitivity to Light
- □ Skin Pain
- □ Skin Swelling
- □ Skin Ulcer
- □ Sores
- □ Spinal Cord Stimulators
- □ Stents
- □ Tattoo(s)
- □ Unusual Bruising
- □ Wounds
- □ Yellowing of the Skin

NEUROLOGICAL

- □ Abnormal Hearing
- □ Abnormal Movements
- □ Abnormal Speech
- □ Abnormal Walking
- □ Behavioral Changes
- □ Behavior Problems
- □ Blackouts
- □ Burning Sensations
- □ Confusion
- □ Dizziness
- □ Fainting
- □ Frequent Falls
- □ Headache(s)
- □ Lack of Coordination/Clumsiness
- □ Lightheadedness
- □ Localized Weakness
- □ Loss of Balance
- □ Loss of Vision
- □ Memory Loss
- □ Migraine(s)
- □ Numbness
- □ Other Visual Disturbances
- □ Radiating Pain
- □ Restless Legs
- □ Saddle Anesthesia (numb around buttocks, perineum, and/or thighs)
- □ Seizures
- □ Seizure- Like Activity
- □ Sensory Loss
- □ Tingling
- □ Tingling/Numbness/Burning Sensations
- □ Tremor(s)
- □ Unsteadiness
- □ Vertigo/Spinning Sensation
- □ Weakness

ENDOCRINE

- □ Change in Body Appearance
- □ Change in Libido
- □ Cold Intolerance
- □ Deepening of the Voice
- □ Excessive sweating
- □ Fatigue
- □ Flushing
- □ Heat Intolerance
- □ Increase in Ring/Shoe/Hat Size
- □ Increased Hunger
- □ Increased Thirst
- □ Increased Urination

HEMATOLOGICAL/LYMPHATIC

- □ Blood Clots
- □ Easy Bleeding
- □ Easy Bruising
- □ Enlarged Lymph Nodes
- □ Slow Healing
- □ Transfusions

PSYCHIATRIC

- □ Abnormal Sleep Pattern
- □ Anxiety
- □ Behavioral Changes
- □ Change in Appetite
- □ Change in Sex Drive
- □ Confusion
- □ Depression
- □ Difficulty Concentrating
- □ Difficulty Sleeping
- □ Hearing Things Others Don't
- □ Hopelessness
- □ Irritability
- □ Lack of Enjoyment
- □ Memory Loss
- □ Mood Swings
- □ Panic Attacks
- □ Paranoia
- □ Posttraumatic Stress Disorder
- □ Restlessness
- □ Seeing Things Others Don't
- □ Sensing Things Others Don't
- □ Tactile Hallucinations
- □ Thoughts of Hurting/Killing Others
- □ Thoughts of Hurting/Killing Yourself