Consultants in Pain Medicine, Inc.

Please remember your fasting instructions, medication instructions, and to bring a driver. If you have not received this information, please call the office at 395-6450 or visit www.beachpain.com.

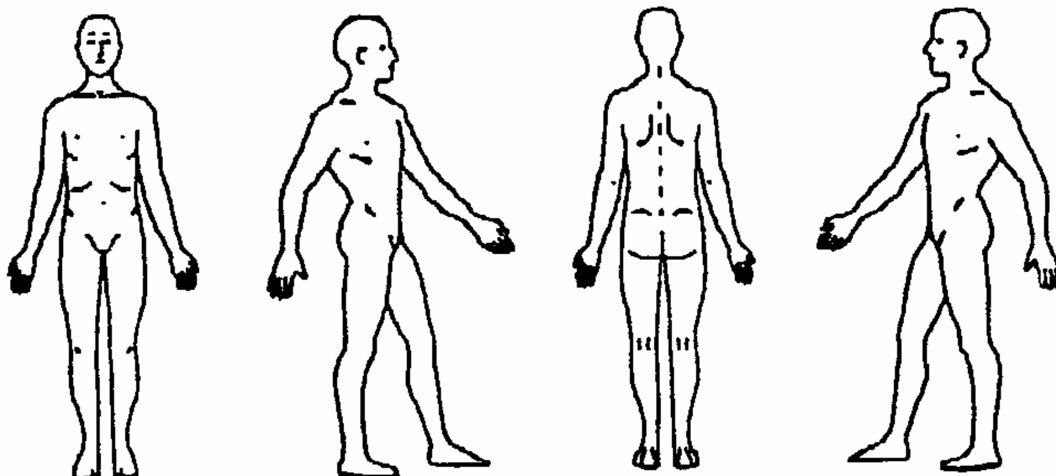
M.D. Signature_________________________

Date_______________

Name: ______________________________ Age______ Height ______ Weight___________

Vitals: BP__________ HR_________ RR___________ T_________ SaO2____________
(will be filled in at consultation)

Please mark exactly where your pain is located: ALLERGY:___________



When did you first notice your pain:____

Did you injure yourself, if so, what was the nature of your injury: __________________________________

____

Please describe what your pain feels like: ____

____

____

____

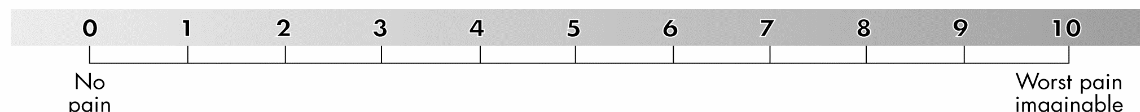
____

Please check any of the following boxes that help describe your pain:

Continuous	Shooting	Burning	Sharp	Tearing
Off and On	Dull	Toothache	Pulling	Knife like

PLEASE RATE YOUR PAIN BELOW

0-10 Numeric Pain Intensity Scale



What makes your pain WORSE: ____

What makes your pain BETTER (check ALL that apply):

Rest Sitting Lying down Standing Nothing at all

OTHER:____

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Do you have numbness in your arms or legs: No Yes
Do you get tingling in your arms or legs: No Yes
Do you have weakness in your arms or legs: No Yes
Since your pain began, have you lost TOTAL control of your bowel or bladder? _____________

What medications have you taken BEFORE and stopped:________________________________
____

Please indicate if you have had the following treatment for your pain:

Epidural Steroid Injection	Physical Therapy	Chiropractor
Acupuncture	Trigger Point Injections	OTHER:______________________

Which has helped your pain:____

Please indication if you have had the following tests for your pain:

MRI CT Scan Electromyelogram / EMG Bone Scan X-Rays

Which other doctors do you see:____

Please indicate all illnesses and disorders for which you are being treated or followed by a doctor:

High Blood Pressure	Diabetes	Liver disease/Hepatitis
Heart Attack	Underactive Thyroid	Kidney Failure
Congestive Heart Failure	Overactive Thyroid	Dialysis
Irregular Heart Beat	Tuberculosis	Urine Infections
Blocked Carotid Artery	Pneumonia	Kidney Stones
Poor Circulation	Asthma	Seizures
Cancer _____________	Heartburn	Stroke
Depression	Acid Reflux	HIV / AIDS

OTHER:
____
____
____
____

Please list all **SURGERY** you have had:

Lumbar /Back	Heart Bypass	Hysterectomy
Neck	Lung___________________	Caesarian Section
Gallbladder Removal	Aortic Aneurysm Repair	Tubal Ligation
Appendix Removal	Carotid Artery Repair	Brain
Tonsil Removal	Leg Artery Bypass	Bowel Removal_________
Bladder	Kidney Stone	Exploration of Bowel
Broken Bone_________	Cataract	Prostate

OTHER:____
____
____

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Please list all your **MEDICATIONS** and doses:

DRUG	DOSE
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Please list all drug **ALLERGIES**:____

Are you taking any **BLOOD THINNING MEDICATIONS**: Yes No

What is your current occupation:____
Does it involve lifting or bending:____
Are you currently out of work on disability:_______________________________________

Do you smoke, and how much:____
Do you consume alcohol and how much:____________________________________
Do you use recreational drugs:____

Are your mother or father deceased, if so from what illness and at what age:________________
____
Do you have any brothers or sisters, please list their ages:_____________________________
Has anyone in your immediate family had a similar medical problem as the one that has brought you here today:____

Do you currently have any of these symptoms:

Severe weight loss	Seizure	Very easy bruising
Very high fever	Stroke	Excessive bleeding
Night sweating	Passing out	Suicidal Thoughts
Nausea / Vomiting	Chest Pain	Blurry vision
Diarrhea	Heart Palpitations	Double vision
Constipation	Irregular Heartbeat	Loss of hearing
Bloody Urine	Chronic cough	Ringing in the ears
Constant Urination	Wheezing	
Painful Urination	Bloody Sputum	

Additional Information: