

University Pain Medicine Center
Didier Demesmin, M.D.
New Patient Intake Questionnaire

Name _____ Date _____
 First Middle Last

Social Security # _____ Driver's License# _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home phone # _____ Work # _____ Cell# _____

Nearest friend or relative not living with you, in case of emergency

Name _____ Relationship _____ Phone _____

Who is Responsible for your bill? Self Spouse Workman's Comp Auto

Insurance Personal Health Insurance Medicare Medicaid Other _____

Are you employed? Yes No Occupation: _____

Business/Employer _____

Activates of Job _____

If unemployed, how long? _____ Is this due to pain? Yes No

Do you plan to go on disability? Yes No

Are you currently involved in a lawsuit? Yes No If yes, please
Explain _____

Who may we thank for referring you? _____

Reason for Visit to this office _____

Location of Pain: Low back Hip Buttock Leg Foot Right Left
 Neck Shoulder Arm Hand Right Left
 Midback Other (Describe) _____

Name: _____ Birthdate: ____ / ____ / ____

Do you have numbness? No Yes – Where? _____

Do you have weakness? No Yes – Where? _____

How long ago did your pain start? _____

Did you have a specific injury that caused your pain? No Yes- Date _____

Type of Injury? Fall Lifting Motor Vehicle Accident Other _____

Are you receiving compensation related to the injury? Yes No

Do you have litigation pending regarding the injury? Yes No

How did your pain begin? Gradually Suddenly

Is your pain constant? Yes No

Has your pain changed? getting gradually worse getting rapidly worse getting better unchanged

Have you ever had similar pain before episode? Yes No

Which words describe the character of your pain?

sharp shooting dull aching cutting stabbing burning throbbing
 tingling cramping crushing stinging electric pressing pounding

What time of day is your pain worse? Morning Afternoon Evening Night

Night and interferes with sleep

What makes the pain worse? lying sitting standing walking lifting other

What makes the pain better? lying sitting standing walking lifting ice
 heat massage other _____

Do you have problems with being unable to control your bowels or bladder Yes No

Have you ever had back or neck surgery? No Yes (Please describe type of surgery and when) _____

Does your pain affect your activities in these different areas?

school work household Chores sexual activity social interactions leisure

Have you consulted any other physicians for your pain? (ex: Pain management, Orthopedic surgeon, Neurologist, Psychiatrist etc) Yes No

If yes who? _____

Have you had any recent diagnostic test regarding your pain?

X-rays CAT scan MRI EMT EMG Myelogram Other _____

Date _____ Facility _____

Please check off any treatments you have undergone for this problem, and if they have helped or not helped your problem:

	Helped		Helped	
	Yes	No	Yes	No
<input type="checkbox"/> Surgery	_____	_____	<input type="checkbox"/> Chiropractor	_____
<input type="checkbox"/> Medications (circle one)	_____	_____	<input type="checkbox"/> Ultrasound	_____
NSAIDS (Motrin, Aleve, etc)			<input type="checkbox"/> Acupuncture	_____
Anti-depressants, Oral Steroids			<input type="checkbox"/> TENS unit	_____
<input type="checkbox"/> Nerve block, steroid	_____	_____	<input type="checkbox"/> Massage Therapy	_____
or trigger point injections			<input type="checkbox"/> Relation	_____
<input type="checkbox"/> Bedrest	_____	_____	<input type="checkbox"/> Exercise	_____

Name: _____ DOB _____

Past Medical History
(Please check if applicable)

Cardiac	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Abnormal Rhythm	Other: _____
Circulatory	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Stroke	<input type="checkbox"/> Aneurysm	Other: _____
Endocrine	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid	<input type="checkbox"/> High Cholesterol	Other: _____
Neurologic	<input type="checkbox"/> Seizure	<input type="checkbox"/> Migraines	<input type="checkbox"/> Head Injury	Other: _____
Pulmonary	<input type="checkbox"/> COPD	<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	Other: _____
Gastro/Renal	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Enlarged Prostate	Other: _____
Infectious	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Lyme's	<input type="checkbox"/> HIV/AIDS	Other: _____
Skeletal	<input type="checkbox"/> Joint replacement	<input type="checkbox"/> Arthritis		Other: _____
Ophthalmic	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Retinal Disease	<input type="checkbox"/> Cataract	Other: _____
Circulatory	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Stroke	<input type="checkbox"/> Aneurysm	Other: _____
Gynecologic	<input type="checkbox"/> Pregnancies _____	<input type="checkbox"/> Miscarriages _____		Other: _____
	<input type="checkbox"/> Pregnancy Complications _____			
Cancer	<input type="checkbox"/> Type _____			
Other	_____			

Past Surgical History
(Please list type, date, and surgeon/hospital)

Family History
(Please check and list parent/sibling with illness/age of death)

<input type="checkbox"/> Heart attack	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Dementia	<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Migraine
<input type="checkbox"/> Brain tumor	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Other _____			
Mother _____			Father _____			
Brothers _____			Sisters _____			

Social History

Marital Status: Married Single Widowed Divorced Separated
Number of Children (if applicable): _____
Smoking Yes No if yes, Packs per day: _____ Number of years _____
Alcohol Yes No if yes, Drinks per day: _____ Drinks per week _____
Drug User Yes No if yes Kind: _____ Frequency _____
History of abuse Yes No Physical Emotional Sexual
List all "Natural" or Herbal remedies, over the counter drugs, vitamins or minerals you are taking.
List: _____

Name: _____ DOB _____

Review of Systems

Below is a list of conditions, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan, and possibility of being accepted for care.

Check any of the following disease you have had:

- | | | | | |
|--|--|--------------------------------------|--|---|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Malaria | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Whoopin Cough | <input type="checkbox"/> Venereal Infection |
| <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Influenza | <input type="checkbox"/> Anemia | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Anemia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Measles | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Shingles | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Eczema |

Please check if any of the following applies to you now:

- | | | | | | |
|-----------------------|---|---|--|---|--------------|
| Constitutional | <input type="checkbox"/> Fever | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain | <input type="checkbox"/> General Weakness | Other: _____ |
| Neurologic | <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Numbness | Other: _____ |
| Eyes | <input type="checkbox"/> Glasses | <input type="checkbox"/> Contacts | <input type="checkbox"/> Blurriness | <input type="checkbox"/> Double vision | Other: _____ |
| Ears/Throat | <input type="checkbox"/> Deafness | <input type="checkbox"/> Ringing | <input type="checkbox"/> Swallowing | <input type="checkbox"/> Hoarseness | Other: _____ |
| Cardiac | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Abnormal Beats | <input type="checkbox"/> Loss of consciousness | | Other: _____ |
| Pulmonary | <input type="checkbox"/> Cough/Cough blood | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Shortness of breath | | Other: _____ |
| Intestinal | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Bleeding | Other: _____ |
| Urinary | <input type="checkbox"/> Frequency | <input type="checkbox"/> Burning | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Bleeding | Other: _____ |
| Muscle/Bone | <input type="checkbox"/> Pain | <input type="checkbox"/> Weakness | <input type="checkbox"/> Cane/Walker | | Other: _____ |
| Endocrine | <input type="checkbox"/> Unexplained | <input type="checkbox"/> Weight Gain/Loss | <input type="checkbox"/> Fatigability | | Other: _____ |
| Circulatory | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke | <input type="checkbox"/> Aneurysm | | Other: _____ |
| Endocrine | <input type="checkbox"/> Unexplained | <input type="checkbox"/> Weight Gain/Loss | <input type="checkbox"/> Fatigability | | Other: _____ |
| Skin | <input type="checkbox"/> Bruising | <input type="checkbox"/> Lesions | <input type="checkbox"/> Birth Marks | | Other: _____ |
| Hematologic | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Transfusion | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Anemia | Other: _____ |
| Psychiatric | <input type="checkbox"/> Depression | <input type="checkbox"/> Addiction | <input type="checkbox"/> Anxiety | | Other: _____ |
| Sleep | <input type="checkbox"/> Gasping for Breath | <input type="checkbox"/> Stop Breathing | <input type="checkbox"/> Insomnia | | Other: _____ |
| Other | _____ | | | | _____ |

Current Medications (Dosages and Frequency, if Known)

- Persantine Ticlid Plavix NSAIDS (Motrin, Aleve, Aspirin etc) Coumadin Dizziness
 Heparin Lovenox Vitamin E Ginko Biloba Ginseng Glucophage
 Other Medications: _____

List of medications you have tried for pain: _____

Allergies

- No Known Drug Allergy Other: _____
 Allergy/Prior Allergic Reaction to: IV Contrast Latex Seasonal Anesthesia
 Medications (State extent and treatment, specify Drug): _____

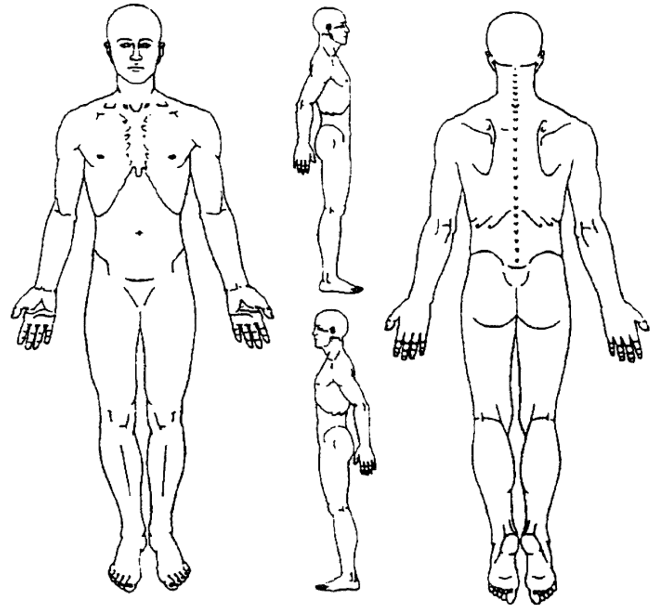
Name: _____ DOB _____

Please mark on the diagram the type of pain and location:

Type of pain currently you are experiencing....

Place appropriate symbol or letter on the diagram.

Ache = AAAAAA
Numbness = NNNNNN
Pins and Needles = OOOOOO
Burning = XXXXXX
Stabbing = /////



Pain can be very difficult to describe. It is helpful to compare the intensity of your pain at different intervals. Please rate the intensity of your pain on a scale from 0 to 10.

0= no pain 10= the worst pain you can imagine

What is your pain now? 1 2 3 4 5 6 7 8 9 10

What is your level of pain when it is most severe? 1 2 3 4 5 6 7 8 9 10

What is your level of pain when it is least painful? 1 2 3 4 5 6 7 8 9 10

On subsequent visits, we will refer to the 0 to 10 pain scale and ask you to rate your pain. Please make an "X" on the line to represent the intensity of your pain.

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain

Name: _____ **DOB** _____

Primary Care Physician

Name: _____
Address: _____
Phone: _____
Fax: _____

Referring Physician

Name: _____
Address: _____
Phone: _____
Fax: _____

Name and Numbers of other specialties that you have seen:

Name: _____
Address: _____
Phone: _____
Fax: _____

Name: _____
Address: _____
Phone: _____
Fax: _____

Name: _____
Address: _____
Phone: _____
Fax: _____

Name: _____
Address: _____
Phone: _____
Fax: _____

Pharmacy Information

Pharmacy: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: () _____ Fax Number () _____