BEACON
Orthopaedics & Sports Medicine

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Interventional Pain Specialist

Please carefully answer these questions so that we can help you decrease pain and increase function.

Patient Name:_____Date:_____
Age today:_____Sex: _M_F Height:_____Weight (lbs):_____
Referring Physician's Name:_____ Phone Number:_____
Primary Physician's Name:_____Phone Number:_____

Please describe your pain and the reason for this visit in your own words in one sentence.
(e.g."I have pain in my low back"): _____

_____

_____

How long ago did you pain start?_____

Under what circumstances did the pain begin?

____Accident/Injury at work	____Accident/Injury	____Secondary to repetitive activity
____Following Illness	____At work, but not an accident	____Motor vehicle accident
____Following Surgery	____Pain began unrelated to activity	

If accident or activity, please describe:_____

_____

_____

Does your pain travel anywhere?_____Yes_____No If yes, where?_____

Where is your pain located? (Circle all that apply)

Head	Face	Neck	Right Shoulder	Left Shoulder	Right Arm
Left Arm	Right Forearm	Left Forearm	Right Hand	Left Hand	Chest
Abdomen	L/R Groin	Mid - Back	Low Back	Right Buttock	Left Buttock
Right Thigh	Left Thigh	Right Leg	Left Leg	Right Foot	Left Foot

Other:_____

Which words describe you pain? (Circle all that apply)

Sharp	Stabbing	Aching	Throbbing	Sore	Unbearable
Tender	Dull	Constant	Intermittent	Cramping	Miserable
Burning	Deep	Radiating	Shooting	Nagging	Exhausting

Do you have any of the following related to your pain? (Circle all that apply)

Numbness	Weakness	Dizziness	Problems with bowels related to pain	Nausea
Tingling	Pins & Needles	Headaches	Problems with bladder related to pain	

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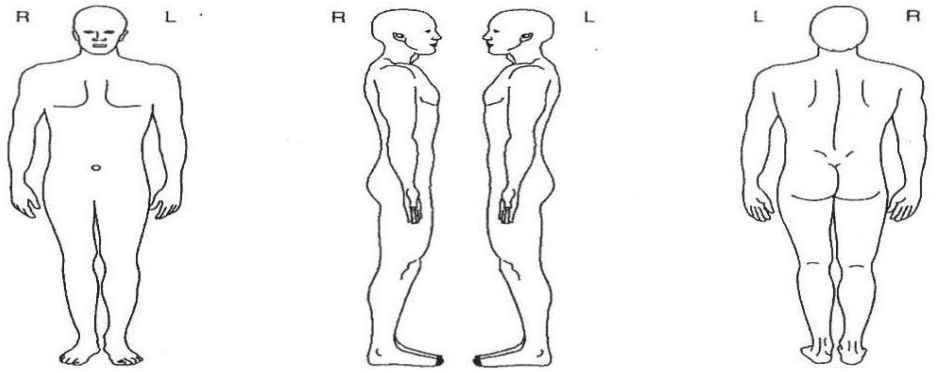
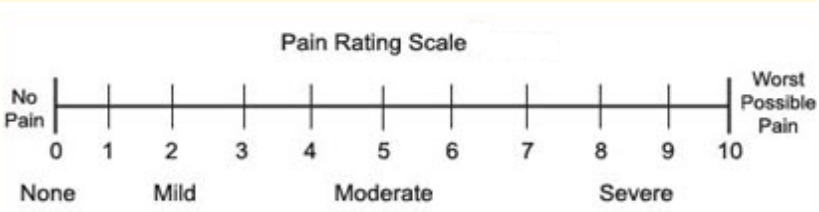
Please shade in the areas where you are having pain in the following pictures: (Shade areas darker for more severe pain and lighter for less severe pain).



SLEEP DISTURBANCE? YES / NO If Yes, whether - Interrupted, Difficulty Falling Asleep, Waking Up Early,
How much sleep (In Hours) a night do you get?_____

Please mark on the scale below where your pain level is **TODAY**.



WORST Pain Level (0-10)_____**LEAST Pain Level** (0-10)_____

What makes your pain worse (circle any aggravating factors)?

Walking Standing Sitting Bending Lying Down Twisting Heat Cold
Anxiety Sneezing Coughing Reaching Lifting Climbing Stairs Bowel Movement Other
(Please Describe:_____

What makes your pain better (circle any relieving factors)?

Heat Cold/Ice Rest Pain Medications Certain Positions (describe)_____
Lying Down Physical Therapy Massage Other (describe)_____

PAST TREATMENTS:

Have You Had Any of the Following Treatments in the Past? How Much Relief Do You Obtain?

TREATMENT	YES	NO	GOOD	MODERATE	MILD	POOR	NO
NSAIDS (Motrin, Aleve, etc.)							
OPIOIDS (Percocet, Vicodin, etc.)							
Physical or Message Therapy							
Tens /Ultrasound /Traction							
Injections (Epidurals, Trigger Point)							
Surgery							
Biofeedback / Hypnosis							
Chiropractic							

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IMAGING STUDIES: Please write the **Date** of the most recent test
MRI/CT SCAN (Spine)_____X-Ray:_____
BONE SCAN:_____EMG:_____

MEDICATIONS: Please List All medications, vitamins, herbs, nutritional supplements you take.

Name of Medication	Dosage	Time/Day	Purpose

If You Have More Medication Please Write Them on a Separate Sheet of Paper

IF YOU ARE TAKING ANY OF THE FOLLOWNG MEDICINES, PLEASE LET US KNOW

___Coumadin (Warfarin) ___Lovenox (Enoxaparin) ___Aggrenox ___Plavix (Clopidogrel)
___Xarelto (Rivaroxaban) ___NSAID ___Ticlid (Ticlodipine) ___Fragmin(Dalteparin)
___Aspirin ___Trental (Pentoxifylline) ___Effient(Prasugrel) ____Eliquis (Apixaban)

ALLERGIES TO MEDICATIONS or SUBSTANCES (LATEX, X-RAY DYE, ECT.):

Medication/ Substance	Type of Reaction

LIST YOUR OTHER MEDICAL PROBLEMS (Circle):

AIDS / HIV	Heart Trouble	Anemia	Hepatitis / Jaundice	Anxiety	High Blood Pressure
Arthritis/Joint Pain	High Cholesterol	Asthma	Kidney Disease	Pneumonia	Blood Transfusions
Bowel Trouble	Reflux / GERD	Cancer	Tuberculosis	Stroke	Depression
Diabetes	Thyroid Disease	Ulcers	Heart Murmur	Chronic Lung Disease	

Other: _____

LIST PREVIOUS SURGERIES: _____ _____
_____ _____

FAMILY HISTORY:

Are You: ___Single ___Married ___Widowed ___Divorced ___Separated
How many Children do you have?_____Are they in good health?_____yes_____no
If No, Please List Major Health Problems:_____
Mother: Alive / Deceased Age:_____ Major Health Problems: _____
Father: Alive / Deceased Age:_____ Major Health Problems: _____

What would you like to be doing that you cannot do now? _____
What are your goals / expectations for coming to our office? _____

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PATIENT NAME_____DATE_____

SOCIAL HISTORY

Education Level:_____Degree:_____

Do you Smoke?____yes____no If yes, how many packs a day?_____How long have you smoked? _____
If no, did you smoke previously?_____How many years ago did you smoke? _____

Do you drink alcohol? _yes _no If yes, how much per day?_____How long have you been drinking? _____
If no, did you drink previously? _yes _no If yes, when did you quit?_____
How much did you drink per day?_____How many years did you drink? _____

Do you have a present drug addiction?____yes____no Do you have a previous one?____yes____no

Do you exercise?____yes____no If yes, what do you do?_____How often? _____

Work Status: ___Full Time ___Part Time ___Retired ___Disability ___Unemployed ___Homemaker
If working, what kind of work? _____
If no, are you receiving any compensation?____yes____no

REVIEW OF SYSTEMS

Do you have or have you ever had any problems related to the following systems? (Please Check)

CARDIAC
__Heart Disease
__Heart Attack / MI
__High Blood Pressure
__Angina/Chest Pain
__Heart Murmur
__Pacemaker
__Cong. Heart Failure
__Other

RESPIRATORY
__Emphysema
__Asthma
__Cough
__Bronchitis
__Sleep Apnea
__Shortness of Breath
__COPD
__Other

NEUROLOGICAL
__Headaches
__Fainting/Dizziness
__Seizures/Convulsions
__Stroke/TIA
__Head Injury
__Balance Problems
__Weakness/Numbness
__Other

GASTROINTESTINAL
__Hernia
__Liver Problems
__Pancreatitis
__Ulcers/Gastritis
__Acid Reflux/GERD
__Constipation
__Diarrhea
__Other

MUSCULOSKELETAL
__Arthritis
__Muscle Pain
__Joint Swelling or Pain
__Joint Stiffness
__Osteoporosis
__Other

PSYCHOLOGICAL
__Anxiety
__Depression
__Panic Attacks
__Mental Disorders
__Considered Suicide
__Other

URINARY
__Kidney Stones
__Frequent Urination
__Painful Urination
__Blood in Urine
__Urine Retention
__Other

IMMUNOLOGICAL
__HIV / AIDS
__TB
__Hepatitis
__Cancer
__Swollen Glands
__Other

SKIN
__Psoriasis
__Open Sores
__Skin Cancer
__Skin Rash
__Other_____

HEAD / NECK
__Eye Glasses
__Glaucoma
__Double Vision
__Persistent Stiff Neck
__Other_____

ENDOCRINE
__Diabetes
__Thyroid Problems
__Cortisone Replacement
__Pituitary Problems
__Other_____

HEMATOLOGIC
__Anemia
__Blood Clots
__Easy Bruising
__Bleeding Problems
__Other_____

CONSTITUTIONAL

__Fever __Chills __Weight Change – Lost/Gained – how much?_____In how long?_____

__Difficulty Sleeping __Other_____

Physician Use Only: (Notes/Comments):_____