

LAKESHORE BONE AND JOINT INSTITUTE
PAIN INFOMEDICAL FORM

NAME: (please print) _____

DATE OF BIRTH: _____ AGE: _____ Today's
Date _____

Referring Physician: _____ Medical Doctor: _____

Describe in detail the problem you are seeing the doctor for today:

When does it hurt?: _____ When did it start?: _____

Did it start suddenly or gradually? _____

Is it the result of an accident? YES _____ NO _____

Is it a work related injury? YES _____ NO _____

Describe your pain (please circle)

Shooting Numbness Tingling Itching Burning Aching Cramping

Throbbing Sharp Dull Pressure Weakness Other _____

If 0 is no pain and 10 is the worst pain imaginable, how would you rate your average pain?

Pain Score Average 0 1 2 3 4 5 6 7 8 9 10 Pain Score Max 0 1 2 3 4 5 6 7 8 9 10

What makes it feel better?: _____ Worse: _____

Pain Symptoms Aggravated By: Walking Standing Sitting Cold Heat Other

Have you changed jobs or stopped work because of your pain? YES _____ NO _____

Does your pain affect your sleep? YES _____ NO _____

Is this preventing you from doing normal activities? YES _____ NO _____

When, during the day, is your pain the worst? _____
the best? _____

Are you under any pressure at home or work? YES _____ NO _____

If yes, please explain: _____

Do you have an attorney helping you? YES _____ NO _____

Check if you have had the following treatments in the past for your current pain:

- Physical Therapy
- Steroid Injections
- Surgery
- Nerve Block
- Other

What treatments have made your pain better? _____

PAST MEDICAL HISTORY/Review of Symptoms Please check if you have or have had any of the following:

Arthritis		Blood Clots		Kidney Problems	
Osteoporosis		Heart Murmur		Glaucoma	
Heart Problems		Pacemaker		Urinary Tract Infections	
Heart Attack		Phlebitis		Diabetes	
Heart Valve Problems		Breathing Problems		Cancer (Type?)	
Poor Circulation/PVD		Asthma		Stomach Problems/Ulcers/Reflux	
High Blood Pressure		COPD/Emphysema		Psychiatric Problems	
Neuropathy		Depression		Thyroid Problems	
Recent weight loss		Recent weight gain		Hepatitis/Liver problems	
Seizures		Headaches		Shingles	

OTHER/COMMENTS: _____

ALLERGIES: YES _____ NO _____

If you have any allergies or drug sensitivities, please list and describe:

MEDICATION: _____

LATEX OR RUBBER ALLERGY, if yes, please describe reaction: _____

DYE or SHELLFISH ALLERGY, if yes, please describe reaction: _____

OTHER ALLERGIES: _____

SURGICAL PROCEDURES Please list any surgeries you have had in the past and the year the surgery was done. Also, list if you had any complication during or following the surgery.

- _____
- _____
- _____
- _____
- _____

PERIOPERATIVE RISK FACTORS: Check if you are on any of the following medications:

Prednisone/Steroid	Aspirin	Blood Pressure	Seizure Medicine
Coumadin/Blood Thinner	Arthritis Medicine	Heart Medicine	Insulin

MEDICATIONS: Please list current medications with dose and frequency.

Pain Medications:

dose

frequency

Other Medications:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Pain Medications tried in past:

_____	_____
_____	_____

Primary Pharmacy Name and
 Phone: _____



FAMILY HISTORY: Please list family members, whether living or deceased, their current age or age at time of death and if they had any of the following diseases:

	YES	NO	Which Immediate Family Member?
Diabetes			
Cancer			
Heart Disease			
MI/Heart Attack			
Bleeding Disorder			
Arthritis			
Stroke			
Kidney Disease			

SOCIAL HISTORY: Please answer the following to the best of your ability:

Marital Status: Married Divorced Single Widowed Partner

Occupation: _____

Does it involve: standing walking lifting operating machinery

Alcohol Use: None Minimum Moderate Heavy

Caffeine Use: None Minimum Moderate Heavy

Do you smoke? YES NO How many packs per day? _____

Did you ever smoke? YES NO If yes, when did you quit? _____

History of Recreational Drug use? YES NO

Height _____ **Weight** _____

Patients :Please fill out pain diagram on the next page!

For Office Use Only:

BP _____ / _____ P _____

Mental Status: Alert & Oriented X3 Other _____

Obese: Yes No Sleep Apnea: Yes No Treatment: _____

HEENT: No Exam WNL Abnormal _____

Lungs: Clear Rales Wheezes Other _____

CV: No Exam RRR/S1 S2 normal Murmur Other _____

Upper Extremities: Normal Edema Cyanosis Pallor Coolness Warmth Allodynia
 Hair Changes Sudomotor Changes Asymmetry _____

Lower Extremities: Normal Edema Cyanosis Pallor Coolness Warmth Allodynia
 Hair Changes Sudomotor Changes Asymmetry _____

Gait : Normal Abnormal _____

Motor Exam: LE Normal Abnormal _____

UE Normal Abnormal _____

Reflexes: Normal Abnormal _____

Sensory Exam: Normal Abnormal _____

Vascular Exam Normal Abnormal _____



Patient Name _____

On the following diagram, mark the areas on your body where you feel the following sensations
(Mark the diagram using the following symbols):

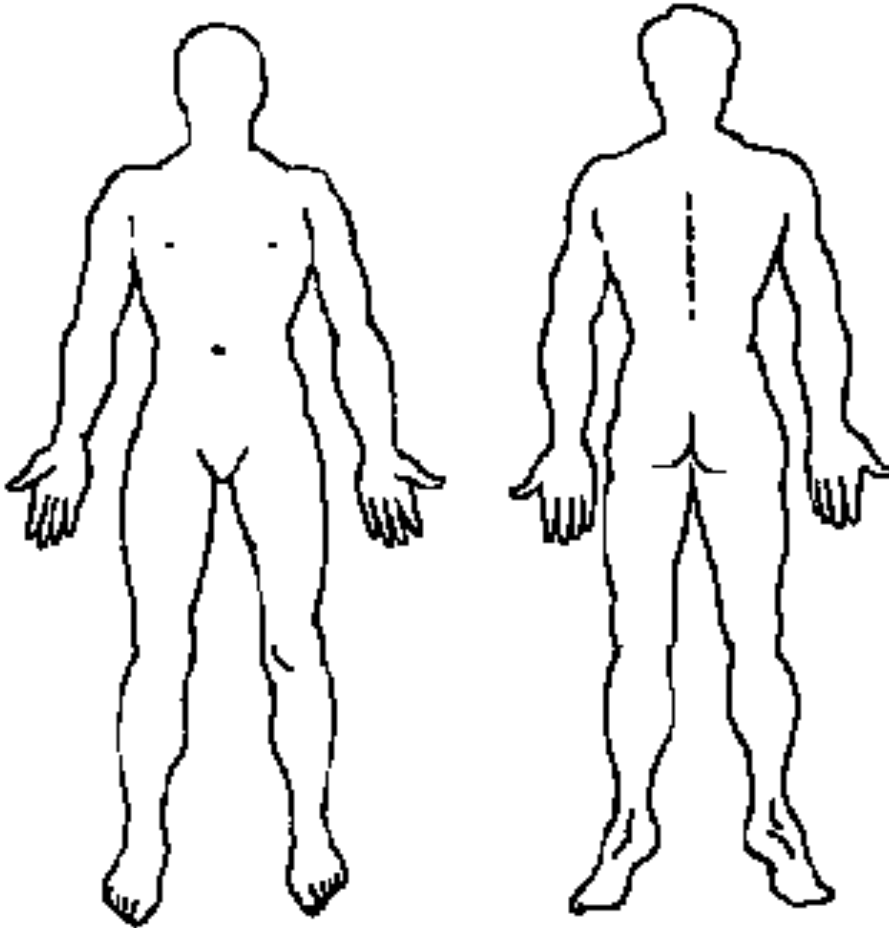
Ache
++++

Numbness
====

Pins and Needles
oooo

Burning
XXXX

Stabbing
////



**For Office Use:
Problem List**

1. _____

4. _____

2. _____

5. _____

3. _____

6. _____