

Susquehanna Valley Pain Management Updated Patient Health History

The following information is very important to your treatment. Please take time to fully and completely fill out this important information. We are counting on you!

Name: _____ Date of Birth: _____
Social Security Number: _____ Age: _____

Chief Complaint

(Reason for today's visit) What kind of symptoms are you having? Include numbness, tingling, weakness of arms or legs, etc. _____

Did previous injections help with your symptoms? _____

Past Medical History

Please list any changes to your health since your last visit. (For example have you started treatment for high blood pressure or diabetes?)

Surgeries Since Last Visit

Diagnostic Studies Since Last Visit

Study _____ When _____ Where _____

Study _____ When _____ Where _____

Medications

List **any** medications, vitamins and/or herbal supplements that you take.

_____	Dose _____ mg	_____	Times per day
_____	Dose _____ mg	_____	Times per day
_____	Dose _____ mg	_____	Times per day
_____	Dose _____ mg	_____	Times per day
_____	Dose _____ mg	_____	Times per day
_____	Dose _____ mg	_____	Times per day
_____	Dose _____ mg	_____	Times per day
_____	Dose _____ mg	_____	Times per day
_____	Dose _____ mg	_____	Times per day
_____	Dose _____ mg	_____	Times per day

Please list any allergies to medications: _____

Review of Systems

Constitutional Symptoms

Poor general health lately.....No Yes
Recent weight change.....No Yes
Fever.....No Yes
Fatigue.....No Yes

Eyes

Eye disease or injury.....No Yes
Wear glasses/contacts.....No Yes
Glaucoma.....No Yes
Cataracts.....No Yes

Ear/Nose

Hearing loss.....No Yes
Wear hearing aids.....No Yes
Nose bleeds.....No Yes

Neurological

Frequent/recurring headaches.....No Yes
Lightheadedness or dizziness.....No Yes
Convulsions or seizures.....No Yes
Stroke.....No Yes
Head injury.....No Yes

Cardiovascular

Heart trouble.....No Yes
Chest pain or angina.....No Yes
Palpitations.....No Yes
High Blood Pressure.....No Yes
Swelling of ankles, hands, or feet.....No Yes

Respiratory

Chronic or frequent cough.....No Yes
Spitting up blood.....No Yes
Shortness of breath at rest.....No Yes
Shortness of breath with exercise.....No Yes
Asthma or wheezing.....No Yes

Gastrointestinal

Loss of appetite.....No Yes
GERD.....No Yes
Nausea or vomiting.....No Yes
Constipation.....No Yes
Frequent diarrhea.....No Yes
Ulcer (stomach or duodenal).....No Yes

Genitourinary

Frequent urination.....No Yes
Incontinence.....No Yes
Kidney stones.....No Yes

Musculoskeletal

Joint pain.....No Yes
Joint stiffness or swelling.....No Yes
Weakness of muscles or joints.....No Yes
Muscle pain or cramps.....No Yes
Back pain.....No Yes
Neck pain.....No Yes
Difficulty walking.....No Yes
Cold extremities.....No Yes

Endocrine

Glandular/hormonal problem.....No Yes
Thyroid disease.....No Yes
Diabetes.....No Yes

Hematologic/Lymphatic

Cuts slow to heal.....No Yes
Bleeding/bruising tendency.....No Yes

Allergic/Immunologic

History of skin reaction or other adverse reaction to:
Morphine, Demerol or other narcotic.....No Yes
Penicillin or other antibiotic.....No Yes
Novocain or other anesthetic.....No Yes

Infections

Do you currently have tuberculosis?No Yes
Have you ever had an infection requiring long-term antibiotics or other medications?No Yes

Cancer

Type: _____
Chemotherapy.....No Yes
Radiation.....No Yes
Currently being treated.....No Yes

Smoking

No Yes _____ packs per day

Please state: Height _____

Weight _____

The above is true and correct to the best of my belief.

Patient Signature or Signature of Person completing the form.

Date: _____

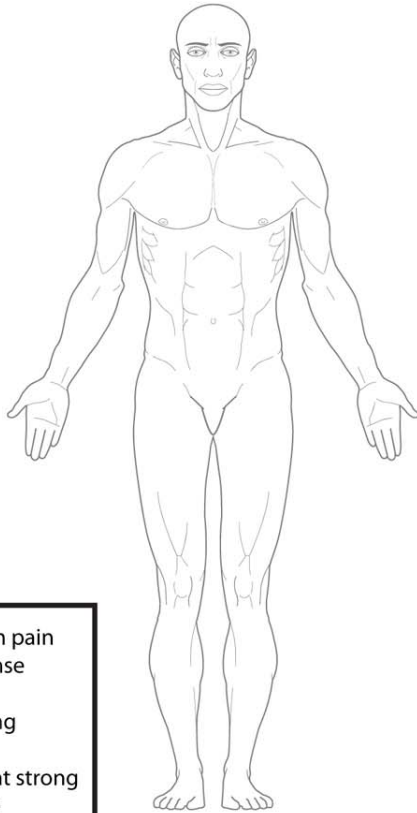
Please indicate your level of pain using a scale of 0-10 (0 is no pain, 10 is the worst pain imaginable.)

Pain level at its lowest (0-10): _____

Pain level at its most intense (0-10): _____

Current pain level (0-10): _____

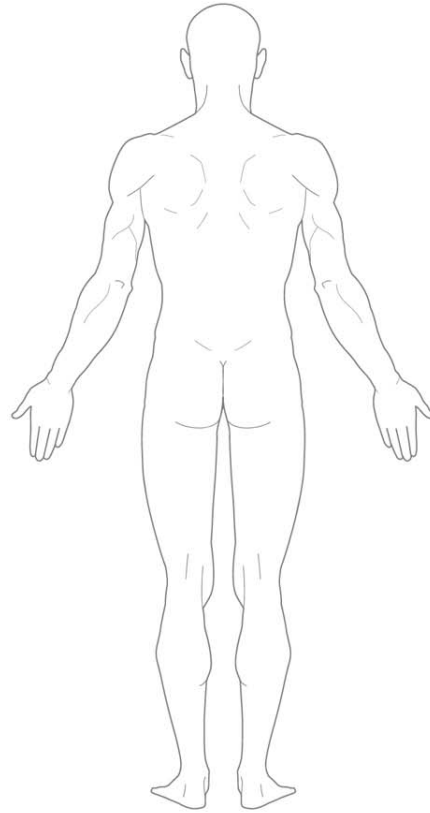
USING THE DIAGRAM BELOW, PLEASE INDICATE WHERE YOUR PAIN IS LOCATED.



Front



Left side



Back



Right side

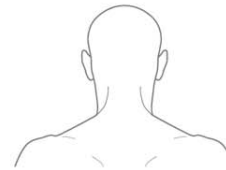
- 10 - Maximum pain
- 9 - Very intense
- 8 - Intense
- 7 - Very strong
- 6 - Strong
- 5 - Somewhat strong
- 4 - Moderate
- 3 - Weak
- 2 - Very, very weak
- 1 - Slight pain
- 0 - No pain



Front



Left side



Back



Right side

BP: _____ **HR:** _____ **Date:** _____

Reviewed by: _____