Outpatient Services Pain Medicine Questionnaire

Who referred you to Pain Medicine?

Who is your Primary Physician?

Have you seen a Pain Management Physician in the past?
If so, who:

Date:

Height: Weight: kg

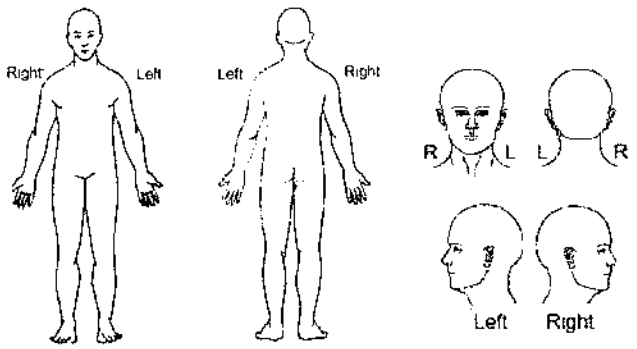
PAIN EXPERIENCE:

What is your pain problem?

When did the present symptoms start? ____/____/____
month day year

Was the onset: ☐ Gradual ☐ Result of an injury ☐ Surgery
☐ Accident Explain:

Mark pain location(s) on diagram(s) below



What makes your pain worse?

What eases or reduces your pain?

Do you have increased pain when you experience the following?

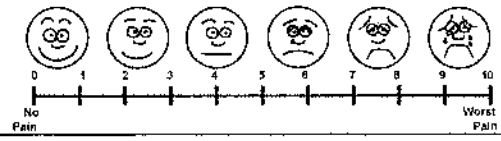
	No	Yes	Location of Pain
Coughing or sneezing	☐	☐	
Bending	☐	☐	
Lifting	☐	☐	
Sitting	☐	☐	
Standing	☐	☐	
Lying Down	☐	☐	
Getting Up or Down	☐	☐	
Walking	☐	☐	

How far can you walk?

Describe your symptoms? (check all that apply)

- ☐ Constant
- ☐ Sharp
- ☐ Burning
- ☐ Tingling
- ☐ Throbbing
- ☐ Intermittent
- ☐ Dull
- ☐ Numbness
- ☐ Loss of Sensation
- ☐ Aching

In general what is your level of pain?



If it is not possible to completely relieve your pain, what level of pain would be acceptable for you to live with?

No pain Most Intense Pain

0 1 2 3 4 5 6 7 8 9 10

If you did reach that level of pain relief, what activities would you engage in that your current pain level prevents you from doing?

Since your pain problem began, which of the following treatments have you had? (check all that apply)

	☐	Medications
	☐	Surgery
	☐	Traction
	☐	Physical Therapy
	☐	TENS
	☐	Chiropractic / Osteopathic Manipulation
	☐	Nerve Blocks or injections
	☐	Biofeedback / Relaxation Training
	☐	Counseling / Psychotherapy
	☐	Other:

FLORIDA HOSPITAL

OUTPATIENT SERVICES
PAIN MEDICINE QUESTIONNAIRE
DH: Personal Health History
927-0002 (6/13) MPC #33789

Patient Label

Outpatient Services Pain Medicine Questionnaire

PAST MEDICAL HISTORY

	NO	YES		NO	YES
High Blood Pressure	☐	☐	Gastro-Intestinal Disease	☐	☐
Heart Disease	☐	☐	Cancer	☐	☐
Stroke	☐	☐	HIV / AIDS	☐	☐
Lung Disease / Asthma	☐	☐	Thyroid Disease	☐	☐
Kidney Disease	☐	☐	Phlebitis	☐	☐
Liver Disease/Hepatitis	☐	☐	Bleeding Disorders	☐	☐
Diabetes	☐	☐	Mental Illness	☐	☐
Arthritis	☐	☐	Alcoholism	☐	☐
Neurological Disease	☐	☐	Low Blood Counts/Anemia	☐	☐
Fibromyalgia	☐	☐	Blood Thinners	☐	☐

Other Serious Illnesses or Injuries: _____

REVIEW OF SYSTEMS (If no problems exist, check the box in the "No" column)

	No	Check any box below that applies
Head / Eyes / Ears Nose / Throat	☐	☐ Headaches ☐ Glasses ☐ Dizziness ☐ Hearing Aids ☐ Difficulty Swallowing
Neurologic	☐	☐ Seizures ☐ Stroke
Cardiovascular	☐	☐ Chest Pain ☐ Heart Murmur ☐ Abnormal Heart Beat ☐ Hypertension
Pulmonary	☐	☐ Wheezing ☐ Shortness of Breath ☐ Obstructive Sleep Apnea ☐ Tuberculosis
Renal / Genito-Urinary	☐	☐ Dialysis ☐ Kidney Transplant ☐ Impaired Kidney Function ☐ Pelvic Pain ☐ Frequent Urination
Gastro-Intestinal	☐	☐ Abdominal Pain ☐ Nausea / Vomiting ☐ Ulcers ☐ Frequent Constipation ☐ Jaundice ☐ Hepatitis
Emotional Status	☐	☐ Depression ☐ Anxiety ☐ Insomnia ☐ Chronic Fatigue
Musculoskeletal	☐	☐ Fibromyalgia ☐ Shoulder / Neck Pain ☐ Back Pain ☐ Arm Pain ☐ Leg Pain
Endocrine	☐	☐ Excessive Thirst ☐ Hot Flashes
General	☐	☐ Weight Loss ☐ Weight Gain
Skin	☐	☐ Bruise Easily ☐ Rash

Other (list):

Person providing information: ☐ Patient ☐ Other: _____

Name: _____ Relationship: _____

Reviewed by RN / RN Authentication: _____

RN - Print Name: _____ Date: _____ Time: _____

ALLERGIES

☐ No Known Allergies

List Any Allergies Below: Describe the reaction below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

PAST SURGERIES / HOSPITALIZATIONS / ACCIDENTS

☐ None (list any below)

Year	TYPE / REASON:

SOCIAL HISTORY/ LIFESTYLE HABITS

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Are you currently working? ☐ No ☐ Yes

Occupation: _____

Did you use or do you currently use:	Type	How much / How often	Last time Used
Alcohol ☐ No ☐ Yes			
Tobacco ☐ No ☐ Yes			
Street /recreational drugs ☐ No ☐ Yes			

Who do you live with? ☐ Alone ☐ Spouse ☐ Roommate(s) ☐ Children ☐ Parents ☐ Significant Other

Do you feel afraid or threatened by someone close to you? ☐ No ☐ Yes

Do you have cultural or spiritual customs important to your care or education? ☐ No ☐ Yes, list: _____

How do you learn best? ☐ Seeing ☐ Hearing ☐ Doing

FAMILY HISTORY

Has a family member ever had a chronic illness or a chronic pain problem? ☐ No ☐ If Yes: explain _____

Patient Label

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Information from: ☐Patient ☐Legally Authorized Person (LAP) ☐Family ☐Patient's Medication List ☐EMS/Transport ☐ Physician Office
☐Medication List from non-FH facility ☐Prior FH record ☐ Other: _____

☐ **NO KNOWN CURRENT HOME MEDICATIONS**

CURRENT MEDICATIONS: Prescription / Over the counter / Vitamins / Herbals / Supplements / Neutraceuticals	**DOSE** Quantity, strength	**ROUTE** Oral, injectable, inhaler, topical	**FREQUENCY** # of times per day, every day (no abbreviations)	*HOSPITAL STAFF TO COMPLETE*		
				LAST DOSE DATE/TIME	*Stopped medication for more than one dose*	
					NO	*YES*

Box(es) not completed for dose, route or frequency – information was not available. Should information become available – complete as applicable.

Authorized Signature / Print Name	Unit	Date / Time	Authorized Signature / Print Name	Unit	Date / Time

☐**NO changes to listed medications** ☐**Your physician has ordered changes as indicated below to some of your listed home medications**

DISCHARGE: NEW MEDICATIONS and/or CHANGES TO PREVIOUS MEDICATIONS *Date / Time:*

MEDICATION(S)	*DOSE*	*ROUTE*	*FREQUENCY*	*NEXT DOSE*	*Rx*	*INSTRUCTIONS*

This information was provided by you or your representative. If this information does not match your home records, or if you have any questions please contact the doctor that prescribed your medication(s).

☐Patient ☐Responsible Person Signature	Print Name / Relationship	Discharge Nurse: Signature/Print Name	Date/Time

Next Provider of Care: Name: _____ Phone: _____

Outpatient Medication List
Recurrent Outpatient Treatments
TAB: Admission Med Reconciliation
DH: Medication Reconciliation Document
602-0741 (10/06) MPC 122005

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Patient Label

DATE	TIME	REVIEWED BY (PRINT NAME)	CHANGED YES / NO	COMMENTS

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Recurrent Outpatient Treatments
Medication List Review
TAB: Admission Med Reconciliation
DH. Medication Reconciliation Document
602-0741 (10/06) MPC 122005

Patient Label