

INITIAL PAIN QUESTIONNAIRE

George Alhaj, MD

The Pain Management Solution PLLC

American board certified in Pain Medicine

American board certified in Anesthesiology

2124 Shadowlake Drive, Building O

Oklahoma City, Oklahoma 73159

Telephone: (405) 378-0600 Fax: (405) 576-3104

www.nopainoklahoma.com

Name: _____

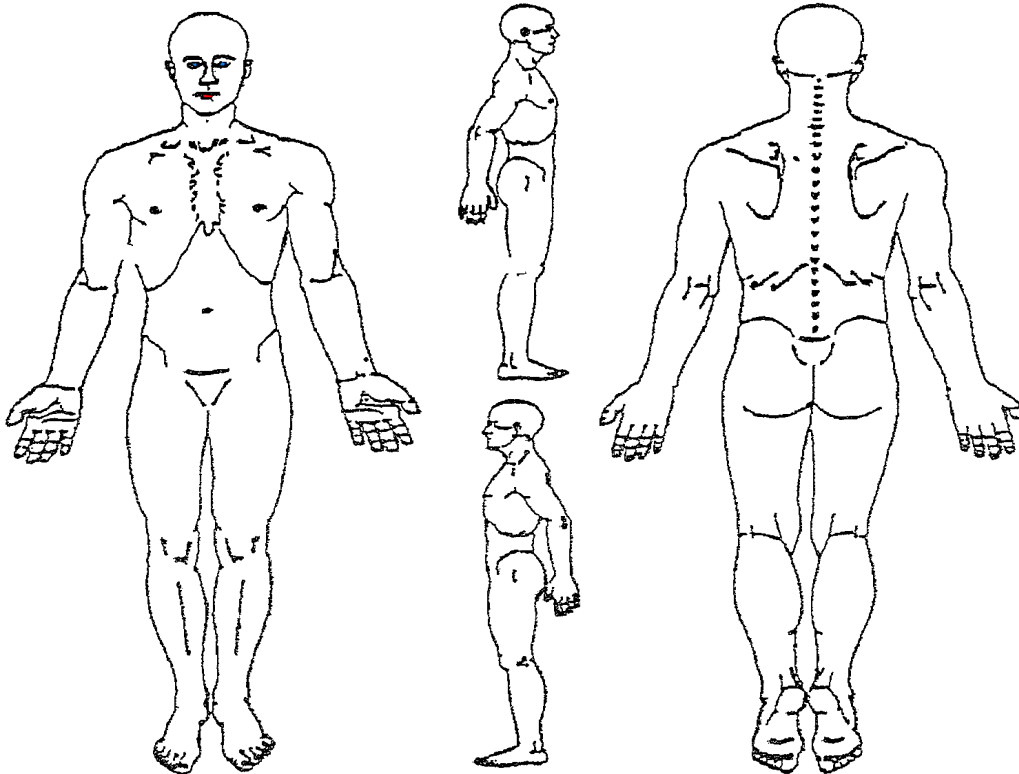
Date: _____ Age: _____ DOB: _____

Who referred you to the Center? _____

Ht. _____ Wt. _____ BP _____ HR _____

CHIEF COMPLAINT: Where are your main pain areas? _____

INDICATE PAIN LOCATIONS: Where does it hurt?



PAIN HISTORY

Circumstances of Onset

Accidental at work _____

Accidental at home _____

Other accident _____

Following illness _____

Following Surgery _____

Pain "just began" _____

Date of injury _____

where were you working? _____

Why do you think you have pain? What do you think is wrong? _____

Do you have any numbness in your arms or legs? YES ____ NO ____ If yes, where? _____

Do you have any tingling sensation in your arms or legs? YES ____ NO ____ If yes, where? _____

Do you have any weakness in your arms or legs? YES ____ NO ____ If yes, where? _____

Do you have incontinence of bowel? YES ____ NO ____

Do you have incontinence of bladder? YES ____ NO ____

Have you had any of the following done concerning your pain area?

X-rays YES ____ NO ____ If Yes, WHEN _____ WHERE _____

CT-scan YES ____ NO ____ If Yes, WHEN _____ WHERE _____

MRI scan YES ____ NO ____ If Yes, WHEN _____ WHERE _____

Discography YES ____ NO ____ If Yes, WHEN _____ WHERE _____

Have you seen any of the following for you pain?

	Name	Treatment Received	Date(s)	Helpful?
Acupuncturist	_____	_____	_____	_____
Anesthesiologist	_____	_____	_____	_____
Chiropractor	_____	_____	_____	_____
Neurologist	_____	_____	_____	_____
Neurosurgeon	_____	_____	_____	_____
Pain Management Physician	_____	_____	_____	_____
Physical Therapist	_____	_____	_____	_____
Primary Care Physician	_____	_____	_____	_____
Psychologist / Psychiatrist	_____	_____	_____	_____
Rheumatologist	_____	_____	_____	_____
Other	_____	_____	_____	_____

What medications or other therapies (such as heat, TENS unit, Biofeedback, Ultrasound, etc.) have you ever tried for your pain?
 (Please indicate how helpful each has been and if there were any associated side effects)

Medication / Therapy	Helpful?	Side Effects

Do you have allergies to any medications? YES _____ NO _____ If Yes, please write below

Medication	Type of reaction

Please list all past and present medical problems. (Example – Diabetes, High Blood Pressure, etc.)

Medical Problem	Details

Please list previous surgeries

Surgery	Date	Details

FAMILY MEDICAL HISTORY

Family	Age	Diseases	If disabled, cause	If deceased, cause of death

Are there any pain problems that run in your family? YES _____ NO _____

Are there other family members on disability for pain related problems? YES _____ NO _____

PATIENT SOCIAL HISTORY

Marital status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
 Children: Ages: _____ Living at home with you? YES _____ NO _____
 Who else lives with you at home? _____
 Use of alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____
 Use of tobacco: Never: _____ Previously, but quit: _____ Current packs per day: _____
 Use of non-prescription drugs: Never: _____ Type / Frequency _____
 Use of caffeine: Never: _____ Type / Frequency _____
 Have you ever had a problem with dependency or abuse of prescription or Non-prescription drugs? YES _____ NO _____
 Have you ever been physically abused? YES _____ NO _____
 Have you ever been sexually abused? YES _____ NO _____
 Excessive exposure at home or work to: Fumes _____ Dust _____ Solvents _____ Particles _____ Noise _____
 Occupation: _____ Hours per day: _____
 Retired: YES _____ NO _____ Disabled: YES _____ NO _____ Since when? _____
 Are you involved in any litigation, workers' compensation claim or disability claim? YES _____ NO _____

REVIEW OF SYSTEMS:

CONSTITUTIONAL SYMPTOMS

Good general health lately YES ___ NO ___
Recent weight change YES ___ NO ___
Fever YES ___ NO ___
Fatigue YES ___ NO ___

EYES

Eye disease or injury YES ___ NO ___
Wear glasses / contact lenses YES ___ NO ___
Blurred vision YES ___ NO ___
Glaucoma YES ___ NO ___

EAR / NOSE / MOUTH / THROAT

Hearing loss or ringing YES ___ NO ___
Earaches or drainage YES ___ NO ___
Chronic sinus problem or rhinitis YES ___ NO ___
Nose bleeds YES ___ NO ___
Mouth sores YES ___ NO ___
Bleeding gums YES ___ NO ___
Sore throat or voice change YES ___ NO ___

CARDIOVASCULAR

Heart trouble YES ___ NO ___
Chest pain or angina pectoris YES ___ NO ___
Palpitations YES ___ NO ___
Exposure to TB? YES ___ NO ___
Swelling of feet, ankles or hands YES ___ NO ___
Murmurs YES ___ NO ___

RESPIRATORY

Chronic or frequent coughs YES ___ NO ___
Spitting up blood YES ___ NO ___
Shortness of breath YES ___ NO ___
Asthma or Wheezing YES ___ NO ___

GASTROINTESTINAL

Loss of appetite YES ___ NO ___
Nausea or vomiting YES ___ NO ___
Frequent diarrhea YES ___ NO ___
Painful bowel movements or constipation YES ___ NO ___
Rectal bleeding or blood in stool YES ___ NO ___
Abdominal pain YES ___ NO ___
Peptic ulcer (stomach or duodenal) YES ___ NO ___
Hepatitis YES ___ NO ___
Pancreatitis YES ___ NO ___

GENITOURINARY

Frequent urination YES ___ NO ___
Burning or painful urination YES ___ NO ___
Blood in urine YES ___ NO ___
Incontinence YES ___ NO ___
Kidney stones YES ___ NO ___
Sexual difficulty YES ___ NO ___
Male – testicle pain YES ___ NO ___
Female – pain with periods YES ___ NO ___
 Irregular periods YES ___ NO ___
 Could you be pregnant now? YES ___ NO ___
 Are you breast feeding? YES ___ NO ___
 Do you experience pain with intercourse YES ___ NO ___

MUSCULOSKELETAL

Joint pain YES ___ NO ___
Joint stiffness or swelling YES ___ NO ___
Weakness of muscles or joints YES ___ NO ___
Muscle pain or cramps YES ___ NO ___
Back pain YES ___ NO ___
Difficulty in walking YES ___ NO ___

INTEGUMENTARY (Skin, Breast)

Rash or itching YES ___ NO ___
Change in skin color YES ___ NO ___
Change in hair or nails YES ___ NO ___
Change in temperature of extremities YES ___ NO ___
Varicose veins YES ___ NO ___
Breast pain YES ___ NO ___

NEUROLOGICAL

Frequent or recurring headaches YES ___ NO ___
Light headed or dizzy YES ___ NO ___
Convulsions or seizures YES ___ NO ___
Numbness or tingling sensations YES ___ NO ___
Tremors YES ___ NO ___
Paralysis YES ___ NO ___
Stroke YES ___ NO ___
Head injury YES ___ NO ___

PSYCHIATRIC

Memory loss or confusion YES ___ NO ___
Anxiety YES ___ NO ___
Depression YES ___ NO ___
Insomnia YES ___ NO ___

ENDOCRINE

Glandular or hormone problem YES ___ NO ___
Thyroid disease YES ___ NO ___
Diabetes (insulin or Non-insulin circle one) YES ___ NO ___
Excessive thirst or urination YES ___ NO ___
Heat or cold intolerance YES ___ NO ___
Skin becoming dryer YES ___ NO ___
Change in hat or glove size YES ___ NO ___

HEMATOLOGIC / LYMPHATIC

Slow to heal after cuts YES ___ NO ___
Bleeding or bruising tendency YES ___ NO ___
Anemia YES ___ NO ___
Phlebitis YES ___ NO ___
Past transfusion YES ___ NO ___
Enlarged glands YES ___ NO ___

ALLERGIC / IMMUNOLOGIC

History of skin reaction or other adverse reaction to:
 Penicillin or other antibiotics YES ___ NO ___
 Morphine, Demerol or other narcotics YES ___ NO ___
 Novocain or other anesthetics YES ___ NO ___
 Aspirin or other pain remedies YES ___ NO ___
 Tetanus antitoxin or other serums YES ___ NO ___
 Iodine or other antiseptic YES ___ NO ___