Medical History

Instructions To do the best possible job with your pain, your doctor needs details about your history, including current and past medical problems, medications, health habits, and family history. For questions that ask about how you feel, please give your best answer yourself. The information about your past medical history may be gathered from both you and your family members.

My name is: _____ ***Date:*** _____

My telephone number is: _____

Pain History Questionnaire

Please give your best answer to the following questions:

1. Where is the pain? (for example: knees, joints, back, head). Does it seem to move anywhere else?

2. How and when did the pain begin?

3. Tell us all you can about the pain:
   What does it feel like (burning, tingling, shooting, sharp, aching), what time of day does it occur, what makes it start, what makes it better, and what makes it worse?

4. Please tell us all you know about previous evaluations of your pain. Particularly, tell us about any X-rays, MRIs, or other procedures done to find out the cause.

Pain History Questionnaire*, continued*

5. What have you been told is causing your pain?

6. Have you had any surgeries or procedures for treatment of your pain? Don't forget therapies and injections. If so, tell us what, where, and by whom. Also tell us how well the treatments worked.

7. What medications have you taken for the pain and how well have they worked? What medicines didn't work out for you and why? (Include both prescription and over-the-counter medicines, creams and herbals. Start back when you first developed your pain problem.)

8. If you have any specific ideas of what should be done for your pain, please write them here.

Persistent Pain Questionnaire

Please choose the best response to the following questions.

1. How much does your pain interfere with walking?

   Not at all **A little** **Moderately** **A lot**

2. How much does your pain interfere with enjoying your life (socializing, travel, hobbies, and work)?

   Not at all **A little** **Moderately** **A lot**

3. How much does your pain interfere with shopping?

   Not at all **A little** **Moderately** **A lot**

4. How much does your pain interfere with driving?

   Not at all **A little** **Moderately** **A lot**

5. How much does your pain interfere with your ability to exercise?

   Not at all **A little** **Moderately** **A lot**

6. How much does your pain interfere with taking a bath?

   Not at all **A little** **Moderately** **A lot**

7. How much does your pain interfere with getting to the toilet on time?

   Not at all **A little** **Moderately** **A lot**

8. How much does your pain interfere with your ability to think clearly?

   Not at all **A little** **Moderately** **A lot**

9. How much does your pain interfere with your sleep?

   Not at all **A little** **Moderately** **A lot**

10. How much does your pain interfere with your appetite?

    Not at all **A little** **Moderately** **A lot**

11. How much does your pain interfere with your mood and spirits?

    Not at all **A little** **Moderately** **A lot**

12. How much does your pain interfere with your relationships with family and friends?

    Not at all **A little** **Moderately** **A lot**

13. How much does your pain interfere with your energy?

    Not at all **A little** **Moderately** **A lot**

Past Medical History

Have you been affected by any of the following problems or conditions? If so, when was it first found?

Condition	When?	Yes	No
Headache		☐	☐
"TMJ" or jaw pain		☐	☐
Dental pain		☐	☐
Neck pain		☐	☐
Problems swallowing		☐	☐
Chronic lung problems		☐	☐
Chest pain		☐	☐
Heart trouble		☐	☐
Stomach or bowel trouble		☐	☐
Pelvic pain		☐	☐
Arthritis		☐	☐
Fibromyalgia		☐	☐
Shoulder or arm pain		☐	☐
Back pain		☐	☐
Hip or knee pain		☐	☐
Muscle pain		☐	☐
Diabetes		☐	☐
Nervous system disorder		☐	☐
Depression		☐	☐
Nervousness, panic attacks		☐	☐
Trouble sleeping		☐	☐
Liver or kidney trouble		☐	☐

Current Medical History

Please list the medical conditions currently affecting you or that you are currently receiving treatment for.

Condition	When Did It Begin?

Psychiatric History

Please list all psychiatric conditions or treatments you have had, with the approximate date of onset for each.

Condition or Treatment	Date

Operations Please list all operations with the date of the operation.

Operation	**Date**

Hospitalizations List the reason and month/year for hospitalizations in the past 10 years.

Reason	**Month/Year**

Family History

Please indicate which family members have had any of the following medical conditions (give the relationship to you, not the relative's name).

Condition	**Family Member(s)**
Diabetes	_____
Arthritis	_____
Depression	_____
Anxiety	_____
Nervous system problem	_____
Pain problems	_____

Health Habits

If you ever smoked, how many packs per day and for how many years? _____

If you no longer smoke, when did you quit?

Have you ever used "street" drugs?

_____ No _____ Yes

Do you drink alcoholic beverages on most days?

_____ No _____ Yes

If yes, how many drinks per day, usually?
(1 drink is 1 beer, 6 oz of wine, or 2 oz of hard liquor)

_____

Have you ever been a heavy drinker (6 drinks a day or more)?

_____ No _____ Yes

Exercise History

In the last few months, how much time each week did you spend in at least moderate exercise?

Less than 15 min.	15 – 60 min.	60 – 120 min.	More than 120 min.

Moderate exercise can be walking, bicycling, swimming, or heavy housework (vacuuming, cleaning). For example: 30 minutes per day, 3 days a week would be 90 minutes total for the week.

What kind of exercise activities do you do?

_____

_____

_____

_____

Social Support and Resources

1. How much help can you expect from family or friends when you are sick?

All I need	Daily help	A few times a week	Once a week	Less than once

2. Who is the person that usually helps you when you are sick?

3. Do you hire people to help you at home? Yes No

4. Do you have enough money to afford the little things that make life pleasant?

Medication History

Please list all **prescription** medicines that you are currently taking.

Name of Medication	**Strength and Times per Day**

Please list all **over-the-counter** medicines that you are currently taking at least once a week.

Name of Medication	**Strength and Times per Day**

Review of Symptoms

Have you been bothered by any of the following problems in the past few months? Please describe any problems briefly, with approximate dates. If you need more room, write on the back of the sheet. Leave the line empty if the problem has not occurred.

Problem	**Description, Date(s)**
Vision or hearing problem	
Lack of energy	
Decreased alertness and fatigue	
Dizziness and unsteadiness	
Passing out spells	
Falls or near falls	
Dry mouth	
Chest pain or discomfort	
Reflux or stomach pain	
Constipation	
Nausea	
Change in appetite	
Weight change	
Swelling	
Night sweats	
Trouble with sleep	
Depression	
Trouble with urination	
Confusion	
Sexuality problem	