ANESTHESIOLOGY OF JUPITER d/b/a JUPITER PAIN MANAGEMENT

NEW PT PAIN MANAGEMENT HEALTH SURVEY

Patient Name: ____ Today's Date: ________________

Height: ______________ Weight: ___________ Sex: Male Female Date of Birth ______________

Referral Source (How you we referred to our office): ____

Who is your Primary Care Physician? Name ____________________________ Phone #: _________________

Email: ____________________________________ Preferred Language English Other __________

Preferred Pharmacy & Telephone Number ____

CURRENT MEDICATIONS:	**NAME**	**STRENGTH**	**FREQUENCY**
Example	Motrin	800mg	2 times a day

PAST MEDICAL HISTORY

 High/Low Blood Pressure ChestPain/MI/Heart Disease Lung Disease Thyroid Problems

 Stroke/TIA Anxiety Kidney/Bladder problems Heart Arrhythmia

 Liver Disease Diabetes: Insulin/Pills/Diet Seizures/NeuroProb/Epilepsy Shortness of Breath

 Ulcer Disease Heart Murmur Cancer ______________________________

Other relevant past medical history ____

SURGICAL HISTORY (Surgery and Year)

____
____
____
____
____
____

FAMILY HISTORY

	Father	Mother	Siblings	
Heart Disease	__	__	__	____________________
High Blood Pressure	__	__	__	____________________
Cancer	__	__	__	____________________
Diabetes	__	__	__	____________________

SOCIAL HISTORY

Smoke Yes No How many packs per day ______________ For how long ________________

How soon after you wake up do you smoke? (minutes) ______________________________

Interested in quitting? ______________________________

Drink Alcohol? Yes No How much and how frequently ______________________________

Have you used drugs other than those for medical reasons in the past 12 months? _______ Yes _______No

If yes, which drug and when was it last used ______________________________

Are you currently working? Yes No If yes, how many hours per day ___________ per week __________

ALLERGIES: List All Medications, Herbal remedies and Foods you are Allergic to and type of reaction to each:

____
____
____
____
____

1210 SOUTH OLD DIXIE HIGHWAY
JUPITER, FL 33458
(561) 263-5073 PHONE (561)263-5074 FAX

When did your Pain Begin? ____Hours ago _____ Days ago _____Weeks Ago _____Years Ago

Was there anything that caused your pain? Car Accident Lifting Work Related Trauma
 Sports Injury After Surgery Malignancy Spontaneous After an Illness Fall

What is the progression of your Pain since it began? Worsening Stable, no change Improving

Please circle your pain level now using this 1-10 rating scale: 1 = no pain 10 = horrible pain.

1	2	3	4	5	6	7	8	9	10

No Pain **Medium Pain** **Worst Pain**

How Frequent is your Pain? Constant Intermittent/Occasional

Please check any of the following activities that make your pain WORSE:

 Sitting Standing Knees Flexed Walking Lying Flat
 Bending or Stooping Changing Position Worse in Morning Worse in Afternoon Straining
 Coughing or Sneezing Lifting Light Exercise Lying Prone (belly down)
 Lying Flat

Please check any of the following activities that make your pain BETTER:

 Sitting Lying Flat Standing Lying Prone (belly down) Knees Flexed Changing Position
 Rest Walking Better in AM Better in PM Bending or Stooping

Is there any Weakness or Numbness with your pain? Yes No **How many hours of Sleep do you get?** ________

Please check any Previous (P) or Current (C) treatments you are participating in:

P C	P C	P C	P C	P C
None	Surgery	Medication	Biofeedback	Hypnosis
Physical Therapy	Epidural Blocks	Nerve/Steroid Blocks	Acupuncture	TENS
Cortisone Pills	Massage Therapy	Exercise	Heat	Ice
Osteopathic/Chiropractic Manipulation		Mental Health Counseling	Trigger Point Injections	

If Current, please tell us where you are receiving treatment: ______________________________

Please check any Diagnostic Testing you have had: MRI CT Scan EMG X-Rays Other

____

____

____

____

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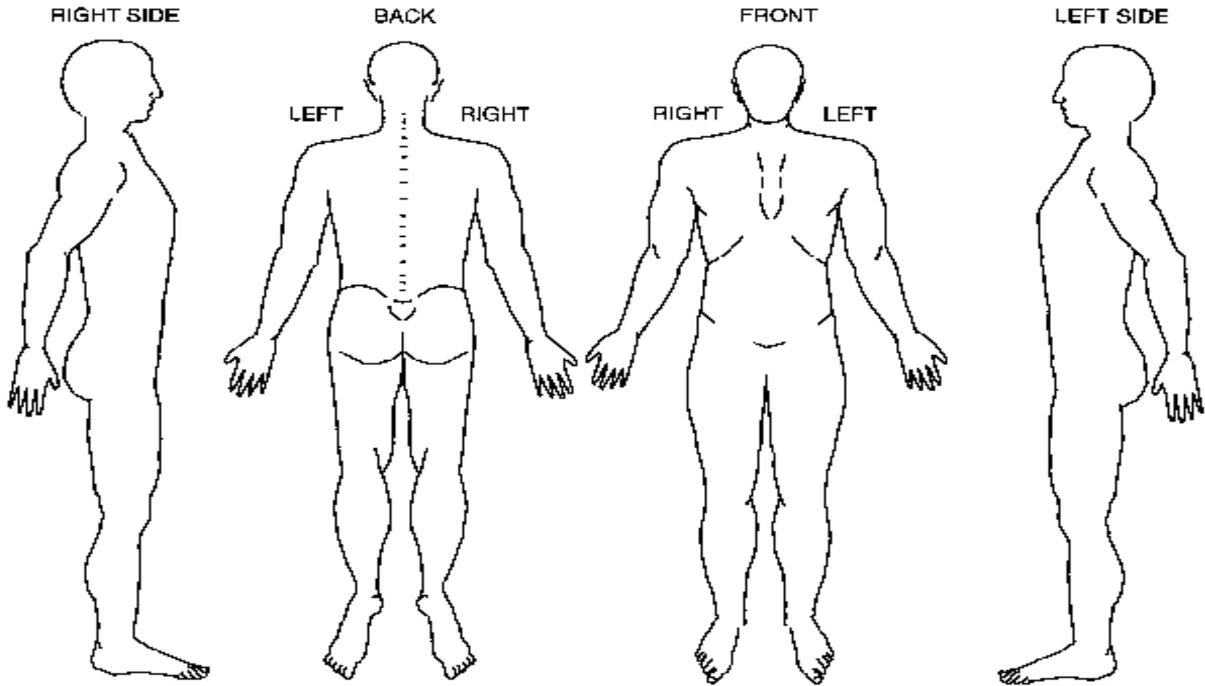
Please mark the area on the diagrams where your pain is located.



Please check the appropriate words that best describe your pain

__ACHING	__SHOOTING	__DULL	__BURNING	__TINGLING	__TIGHT	__CRAMPING
__HOTNESS	__HEAVY	__BRIEF	__NUMBING	__COLDNESS	__INTENSE	__STINGING
__SORENESS	__STABBING	__SHARP	__TRANSIENT	__CONSTANT	__RADIATING	__UNBEARABLE
__SEVERE	__ANNOYING	__ELECTRIC	__PRESSURE	__STABBING	__KNIFE LIKE	

ADDITIONAL COMMENTS: ____
____

Patient Signature ____Date ____________________

Relative or Legal Guardian Name Printed ____

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