Kalamazoo Anesthesiology, PC
Pain Consultants

INITIAL PATIENT INTERVIEW

FULL NAME	AGE	BIRTH DATE	SEX (CIRCLE ONE) M F	HEIGHT	WEIGHT

ALLERGIES

CHIEF COMPLAINT

DESCRIBE PAIN IN YOUR OWN WORDS (ie. Sharp, Burning, Aching, etc)

HISTORY OF PRESENT ILLNESS

DATE OF ONSET OF PAIN	WHAT CAUSED ORIGINAL PAIN

LOCATION OF PAIN

TIME OF DAY BETTER	TIME OF DAY WORSE

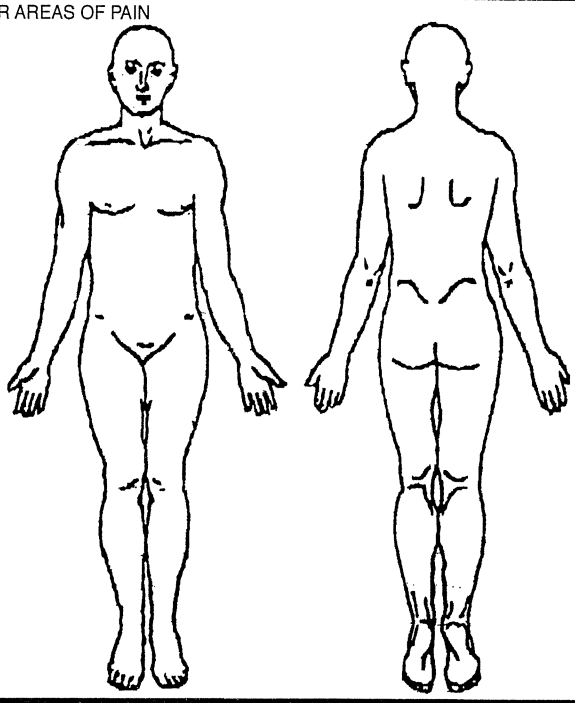
WHAT HELPS PAIN	LOSS OF BOWEL / BLADDER CONTROL ☐YES ☐NO

WHAT MAKES PAIN WORSE

PREVIOUS PAIN MEDS AND DATES TRIED

TYPE OF PAIN ☐CONSTANT ☐INTERMITTENT	RATE SEVERITY (0-10) 0 = None 10 = Unbearable	NUMBNESS OR TINGLING ☐YES ☐NO

COLOR AREAS OF PAIN



PREVIOUS STUDIES

X-RAY ☐ Yes ☐ No

MRI ☐ Yes ☐ No

CT ☐ Yes ☐ No

EMG ☐ Yes ☐ No

PREVIOUS TREATMENTS

Physical Therapy DATE: RELIEF:

Acupuncture

Chiropractor

Tens Unit:

Previous Pain Blocks (Injections):

If you have been to any other pain clinic, please list their names below:

CURRENT MEDICATIONS

NAME	DOSE	NAME	DOSE

	PHYSICIAN SIGNATURE	DATE

7920 Kirkland Court, Portage, Michigan 49024 • 269.381.PAIN or 866.387.PAIN • Fax 269.345.5354

REVIEW OF SYSTEMS	PROBLEMS?		REVIEW OF SYSTEMS	PROBLEMS?	
HEENT			**MUSCULOSKELETAL**		
Eyes (Vision Change)	☐ Yes	☐ No	Back Pain	☐ Yes	☐ No
Ears, Nose, Mouth, Throat	☐ Yes	☐ No	Neck Pain	☐ Yes	☐ No
RESPIRATORY			Headaches	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	**INTEGUMENTARY / SKIN**		
Emphysema / COPD / Shortness of Breath	☐ Yes	☐ No	Rash / Lesions	☐ Yes	☐ No
CARDIOVASCULAR			History of MRSA	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Cancer TYPE TREATMENT	☐ Yes	☐ No
Artificial Valve	☐ Yes	☐ No	**NEUROLOGIC**		
Heart Stents	☐ Yes	☐ No	Seizure	☐ Yes	☐ No
Heart Rhythm Problems	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Leg Pain/Neuropathy	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	**ENDOCRINE**		
GASTROINTESTINAL			Diabetes	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No	Thyroid	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	**HEMATOLOGIC**	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No	Blood Thinners NAME OF MED PRESCRIBING DOCTOR	☐ Yes	☐ No
GENITOURINARY					
Kidneys	☐ Yes	☐ No	Bleeding Problems	☐ Yes	☐ No
Bladder	☐ Yes	☐ No	**PSYCHIATRIC**	☐ Yes	☐ No
LIVER			Depression	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
			Other	☐ Yes	☐ No

IF YES TO ANY ABOVE, PLEASE EXPLAIN PRESENT AND PAST MEDICAL HISTORY:	PAST SURGERIES / PROCEDURES

FAMILY HISTORY (Mother, Father, Siblings)		SLEEP	☐ GOOD ☐ BAD ☐ FAIR
Diabetes	Heart Disease	APPETITE	☐ GOOD ☐ BAD ☐ FAIR
Stroke	Cancer	WEIGHT	☐ GAIN ☐ LOSS ☐ SAME
Other			

SOCIAL HISTORY *Do you use (or have you used any of the following):*

Tobacco ☐ Never ☐ Currently ☐ Quit (year)_____ Type Used ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless
Amount used per day _____ How many years _____

Alcohol ☐ Never ☐ Social / Rare ☐ Daily ☐ Quit (year) _____ Type Used ☐ Beer ☐ Wine ☐ Liquor
Amount used per week _____ 12 oz. Beers _____ 6 oz. Wine _____ 2 oz. Shots

Drug Use ☐ Never ☐ Currently ☐ Quit (year) _____ Type Used ☐ Marijuana ☐ Cocaine ☐ IV Drug Use ☐ Methamphetamines ☐ Other _____

EDUCATION	EMPLOYMENT	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW

WORKERS' COMP / DISABILITY / LAWSUITS (EXPLAIN):	PATIENT SIGNATURE	PHYSICIAN SIGNATURE	DATE