Columbus Pain Center

MEDICAL HISTORY QUESTIONNAIRE

Patient Name _____ SSN _____

Gender: Male Female Date of Birth _____ Age _____

PRESENT MEDICAL HISTORY

Where are you hurting? _____

_____ How long? _____

Was this due to an injury? ( ) No ( ) Yes If yes, please describe _____

Please list any physicians you have seen for this condition _____

PAST MEDICAL HISTORY

Do you currently or have you ever had any of the following: (please circle all that apply)

High Blood Pressure	Stroke	Ulcer	Osteoarthritis	Sleep Apnea
Heart Disease	Bleeding Disorder	GERD/Reflux	Gout	High Cholesterol
Heart Attack	Blood Clots	Asthma	Rheumatoid Arthritis	Kidney Stone
Pacemaker/Implants	Hepatitis	Emphysema	Fibromyalgia	Depression / Anxiety

Cancer – Type _____

Please list any other conditions not mentioned above _____

Please list all diagnostic studies (x-rays, CT, MRI) and dates _____

Please list all surgeries or hospital procedures and dates _____

_____

Please list all allergies to [ ] Foods [ ] Shellfish [ ] Drugs _____

Please list all medications you are currently taking and the physician who prescribes them

Medication name _____ Prescribed by Dr. _____ Dosage _____
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Medication Name _____ Prescribed by Dr. _____ Dosage _____
Medication Name _____ Prescribed by Dr. _____ Dosage _____

FAMILY HISTORY

Please circle any significant health problems in your family history

Heart Disease	Diabetes	High Blood Pressure
Stroke	Cancer	Other _____

SOCIAL HISTORY

Do you.

Use alcohol?	( ) No ( ) Yes	If yes, how much and how often? _____
Use tobacco?	( ) No ( ) Yes	If yes, how much and how long? _____
Use social drugs?	( ) No ( ) Yes	If yes, name and how often? _____

PAIN SCALE (please circle what your pain level is today)

0	2	4	6	8	10
None	Mild	Moderate	Severe	Very Severe	Worst Possible