

DR. RUTH ANDERSON
PATIENT HISTORY FORM – EXTENDED FOLLOW-UP

DATE: _____

NAME: _____ PHONE: _____

ADDRESS (IF CHANGED SINCE LAST VISIT): _____

WHO IS YOUR PRIMARY CARE DOCTOR? _____

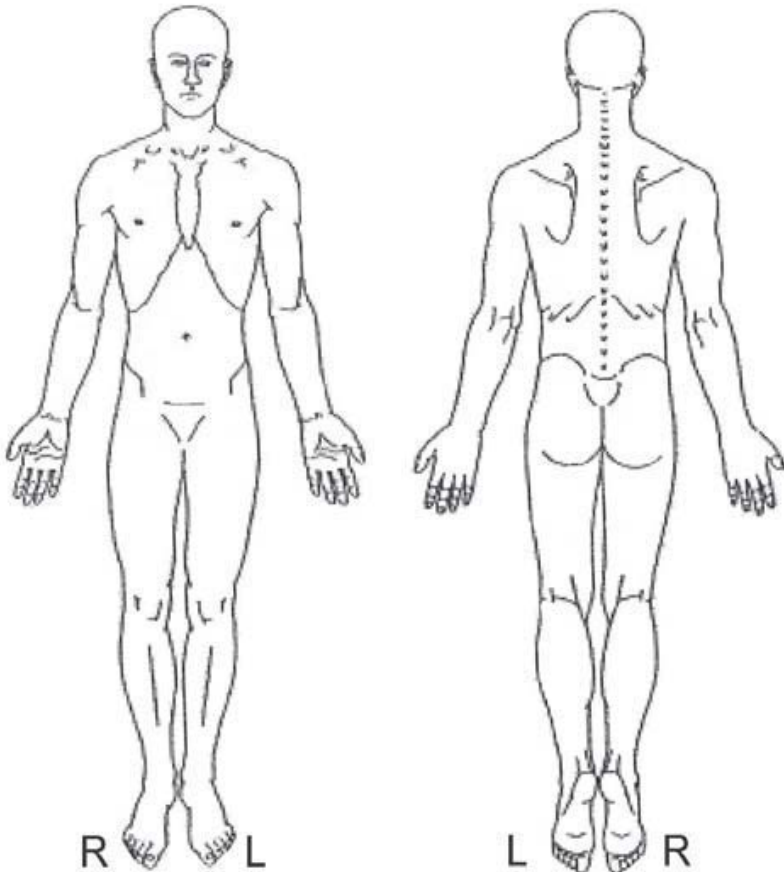
REASON FOR YOUR VISIT: _____ IS THIS NEW OR RECURRING PAIN? _____

HISTORY OF PRESENT ILLNESS

AGE _____ RACE _____ SEX M F

WHO IS COMPLETING THE PAPERWORK? _____

PLEASE DRAW WHERE YOUR PAIN IS LOCATED:



PLEASE DESCRIBE YOUR PAIN:

CONSTANT

INTERMITTENT

BURNING

DEEP/DULL ACHE

FIRE

THROBBING/JABBING

ELECTRIC

SPASM

SHOOTING

TOOTHACHE

KNIFE-LIKE

PLEASE LIST ASSOCIATED SYMPTOMS:

- MUSCLE SPASM
- NAUSEA/VOMITING
- RESTLESS LEGS
- PAIN WITH FIRST STEPS IN THE MORNING
- PAIN THAT WAKES YOU UP AT NIGHT
- FATIGUE
- LEG CRAMPS: RIGHT LEFT OR BOTH LEGS
- FOOT DROP: RIGHT OR LEFT LEG
- LIGHTHEADEDNESS
- SENSITIVITY TO LIGHT
- VISUAL DISTURBANCES PRIOR TO HEADACHE
- NUMBNESS, LOCATION _____
- TINGLING, LOCATION _____
- SWELLING, LOCATION _____

STIFFNESS: () LOW BACK () LEGS () KNEES () HIPS () FEET () NECK () ARMS
() SHOULDERS () HANDS

TENDERNESS: () LOW BACK () LEGS () KNEES () HIPS () FEET () NECK () ARMS
() SHOULDERS () HANDS

WEAKNESS: () LOW BACK () LEGS () KNEES () HIPS () NECK () ARMS
() SHOULDERS () HANDS

PLEASE RATE YOUR PAIN :

0-10 SCALE, WHERE 0/10=NO PAIN AND 10/10 IS SO SEVERE YOU CAN'T EVEN SPEAK

CURRENT PAIN: ____/10 WORST PAIN: ____/10 'BEST DAY' PAIN: ____/10

WAS YOUR ONSET OF PAIN ____ GRADUAL OR ____ SUDDEN?

WHEN DID YOUR PAIN FIRST OCCUR (APPROXIMATE DATE): _____

WERE YOU INJURED OR IN AN ACCIDENT THAT CAUSED YOUR PAIN TO OCCUR:

WHAT MAKES YOUR PAIN BETTER?

- LYING DOWN
- SITTING
- GETTING OUT OF A CHAIR
- BENDING FORWARD
- STANDING
- OTHER, PLEASE EXPLAIN: _____
- WALKING
- REACHING
- TURNING MY HEAD
- TWISTING
- EXERTION/EXERCISE
- POSITION CHANGE
- LEANING ON A CART

WHAT MAKES YOUR PAIN WORSE?

- LYING DOWN
- SITTING
- GETTING OUT OF A CHAIR
- BENDING FORWARD
- STANDING
- OTHER, PLEASE EXPLAIN: _____
- WALKING
- REACHING
- TURNING MY HEAD
- TWISTING
- EXERTION/EXERCISE
- POSITION CHANGE
- LEANING ON A CART

MY PAIN IS WORSE IN THE: ____ MORNING ____ NOON ____ EVENING ____ DURING SLEEP

PLEASE CHECK ALL TREATMENTS YOU HAVE TRIED AND THEN INDICATE IF THEY WERE HELPFUL OR NOT

	Helpful	Not Helpful	Details
Ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Biofeedback/ Relaxation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Home Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Massage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Accupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Laser Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Nerve Blocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
TENS/ MENS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Trigger Point Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Epidurals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Pain Management Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

PLEASE CHECK ALL MEDICATIONS THAT YOU HAVE TRIED AND WHETHER THEY WERE HELPFUL OR NOT

ANTI-INFLAMMATORY MEDICATION

NSAIDs	Helpful	Not Helpful	Details
Advil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Aleve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Celebrex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Diclofenac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Mobic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other (<i>list in details</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

MUSCLE RELAXANTS

Muscle Relaxants	Helpful	Not Helpful	Details
Flexeril	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Soma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Skelaxin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Zanaflex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other (<i>list in details</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

NARCOTIC PAIN PILLS

Short Acting Narcotics	Helpful	Not Helpful	Details
Tramadol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Vicodin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Perocet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Darvocet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Actiq	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Dilaudid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other (<i>list in details</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Long Acting Narcotics	Helpful	Not Helpful	Details
Duragesic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Morphine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
OxyContin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Methadone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other (<i>list in details</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

NEUROPATHIC AGENTS

Neuropathic Agent	Helpful	Not Helpful	Details
Neurontin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Lyrica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Topamax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Cymbalta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Savella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other (<i>list in details</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

OTHER MEDICATIONS

Other	Helpful	Not Helpful	Details
Tylenol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Lidoderm Patch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Voltaren Gel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Flector Patch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other (<i>list in details</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

DURING THE PAST MONTH, HOW MUCH DID YOUR PAIN INTERFERE WITH:

REVIEW OF SYSTEMS

PLEASE CIRCLE ALL SYMPTOMS YOU HAVE EXPERIENCED RECENTLY (PAST 6 MONTHS)

FEVER, CHILLS, FATIGUE, POOR APPETITE, POOR SLEEP, WEIGHT LOSS, WEIGHT GAIN

HEARING LOSS, SORE THROAT, SWOLLEN GLANDS, BLURRY VISION, DECREASED VISION

SHORTNESS OF BREATH, WHEEZING, COUGH

CHEST PAIN, PALPITATIONS, SWELLING OF LEGS, RACING HEART

RASH, ITCHING, NEW SKIN LESIONS, EASY BRUISING

NEW JOINT PAIN, JOINT SWELLING, STIFFNESS, WEAKNESS

ABDOMINAL PAIN, NAUSEA, VOMITING, DIARRHEA, CONSTIPATION, HEART BURN

HEADACHE, DIZZINESS, LOSS OF CONSCIOUSNESS, NUMBNESS, TINGLING

DEPRESSED MOOD, ANXIOUS MOOD, ABNORMAL THINKING/INTELLECT