COASTAL INTERVENTIONAL PAIN ASSOCIATES

CONSULTATION AND EVALUATION

Date____________

Name_______________________________________ DOB________________________Age_____________

Referring Physician/Specialist____

Primary Care Physician____

Other Physicians/Specialists you currently see____

Attorney/Litigation (related to your pain condition)_______________________________________

Is this a Workers Compensation injury: YES______ NO_______ Date of Injury___________________________

What are your goals/expectations in coming to this office?___________________________________

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HEALTH MAINTENANCE:

Tobacco use: Yes____ No____, # of years_____, # of packs per day______

Alcohol use: # of drinks per average week______

Previous history of alcoholism? Yes_____ No_____

Family history of alcoholism? Yes_____ No_____

Family history of drug abuse/misuse? Yes_____ No_____

Illicit/Illegal drug use? Yes_____ No_____

Treatment for chemical dependency? Yes_____ No_____

Hours of sleep each night: _______

Awaken due to pain? Yes____ No____ How Often?________________

Difficulty falling asleep? Yes____ No____ Difficulty staying asleep? Yes____ No____

Current Weight______
Have you gained weight in the last year? Yes___ No___, # of Pounds________

Have you lost weight in the last year? Yes___ No____, # of Pounds________

Amount of exercise you do: None or Less than 3 X per week or More than 3 X per week or Daily

Type of exercise you do____

SOCIAL HISTORY:

Marital Status? S M W D Number of children______

Education? 8th grade High School College Post-Graduate

Currently Employed? Yes_____ No_____ Retired______ Disability______

Type of work you do or did?____

Employer________________________

Last date of employment________________________ Returning to work?_______________

PAST MEDICAL HISTORY: (circle all that apply to you)

Heart attack/MI	Stroke/TIA	Seizures	Kidney failure/dysfunction
Asthma	Arthritis	Liver failure/dysfunction	Hepatitis
Irregular heart beat	↑Blood Pressure	Stomach Ulcers	Diabetes
Migraine Headaches	Fibromyalgia	Thyroid Disorder	Poor Circulation (PAD)
Bleeding Disorder	Depression	Cancer, list type______________________________	

Other conditions____

SURGICAL HISTORY:

(List all previous surgeries)

1.____ Date______________________
2.____ Date______________________
3.____ Date______________________
4.____ Date______________________
5.____ Date______________________
6.____ Date______________________
7.____ Date______________________
8.____ Date______________________

ALL CURRENT MEDICATIONS: (strength and frequency must be included)

	Name	Strength	How Often		Name	Strength	How Often
1				6			
2				7			
3				8			
4				9			
5				10			

DRUG ALLERGIES:

1____________________	Reaction____________________
2____________________	Reaction____________________
3____________________	Reaction____________________
4____________________	Reaction____________________

FAMILY HISTORY:

Mother: Living? Yes______ No______ Age______
Past Medical History________________________________

Father : Living? Yes______ No______ Age______
Past Medical History________________________________

Brothers: #______ Past Medical History________________________________

Sisters: #______ Past Medical History________________________________

REVIEW OF SYSTEMS: (Circle all that apply to you)

General:
- Weight Gain
- Weight Loss
- Fever
- Night Sweats
- Anemia

Skin:
- Hives
- Yellow Jaundice
- Flushing
- Easy Bruising
- Rash

Head/Eyes:
- Blurred Vision
- Double Vision
- Pain with Bright Light
- Blindness
- Cataracts
- Glaucoma

Ears/Nose/Throat:
- Ringing in Ears
- Sore Throat
- Hearing Loss
- Hoarseness
- Bleeding Gums

Neurologic:
- Headaches
- Seizures
- Dizziness
- Black out Spells
- Paralysis
- Memory Loss
- Hallucinations
- Anxiety/Depression
- Disorientation

Endocrine/Hormonal
- Frequent Urination
- Excessive Thirst
- Cold Intolerance
- Diabetes
- Low Thyroid
- High Thyroid

Cardiac/Vascular:
- Chest Pain
- High Blood Pressure
- Irregular Heart Beats
- Heart Murmur
- Swelling in Legs
- Difficulty Breathing Lying Flat

Respiratory:
- Cough
- Coughing up blood
- Wheezing
- Pneumonia
- Tuberculosis
- Short of Breath

Gastric/Intestinal:
- Difficulty Swallowing
- Nausea
- Constipation
- Diarrhea
- Throwing up Blood
- Reflux
- Colitis
- Hiatal Hernia

Urinary:
- Frequent Urination
- Frequent Nighttime Urination
- Feeling of Urinary Urgency
- Blood in Urine
- Incontinence
- Painful Urination
- Difficulty Starting Urination
- Kidney Stones
- Impotence

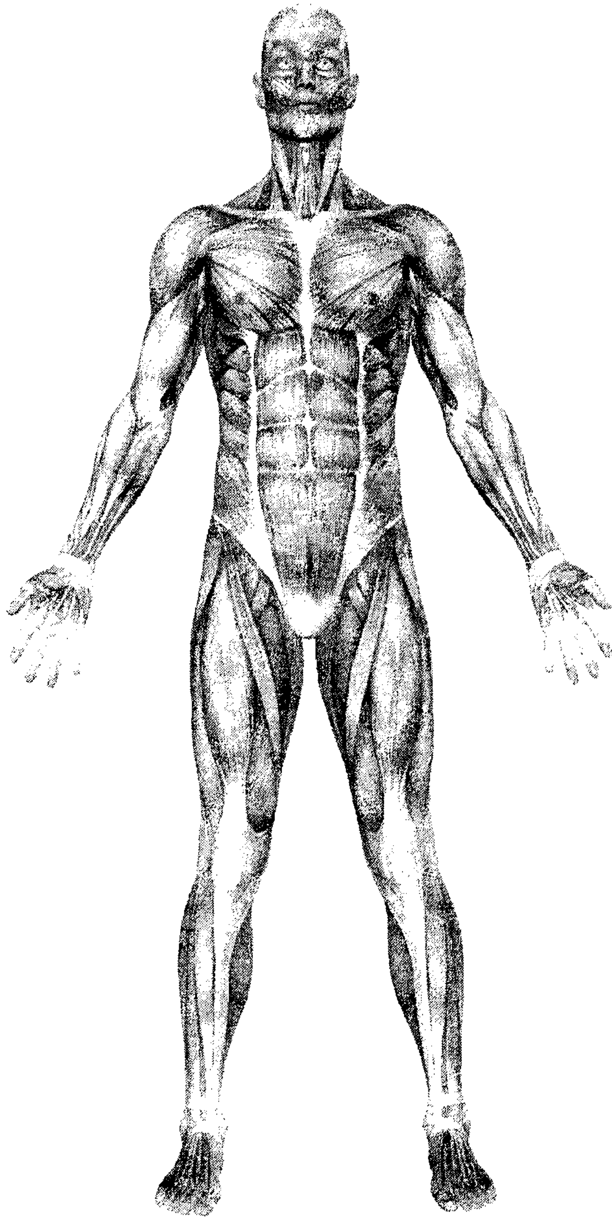
Musculoskeletal:
- Muscle Weakness
- Joint Pains
- Fractures
- Osteoporosis

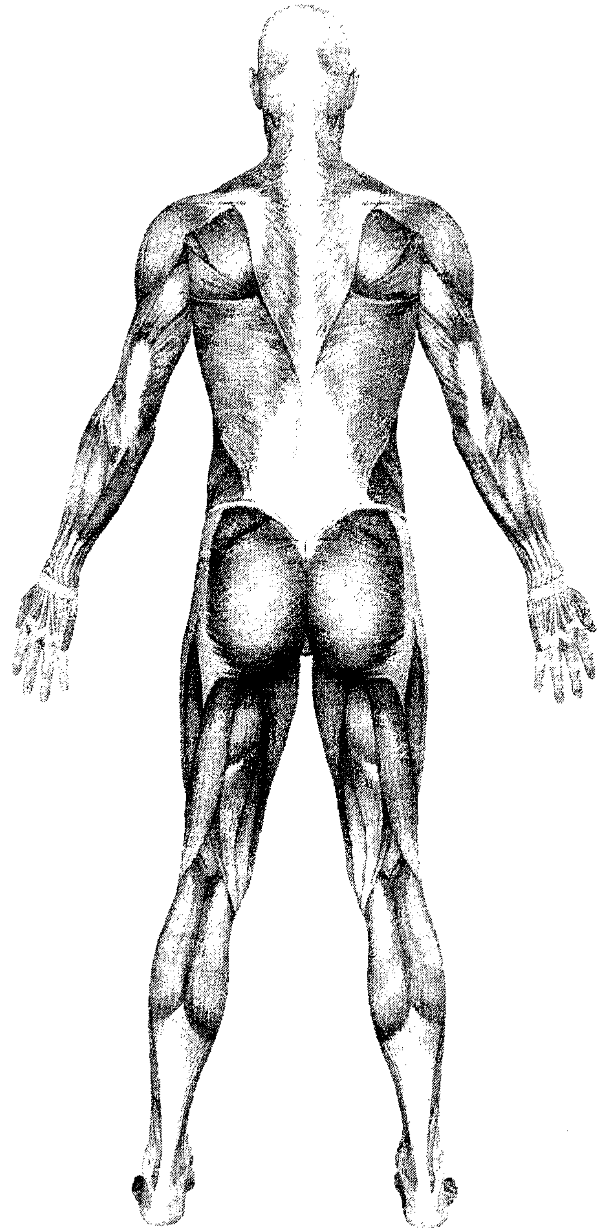
Ambulation Aids:
- Cane
- Walker
- Crutches
- Wheelchair

Coastal Interventional Pain Associates

Name: ______________________ Date: ___________________

Mark the area(s) on the "Pain Man" that correspond to your pain





xxxx = Burning
oooo= Ache/Dull

^^^^ = Stabbing
~~~ = Throbbing

----> = Radiate
//// = Numbness
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