Palmetto
Spine & Pain Care Consultants

Health History Form

Date: _____

First Name: _____ Middle: _____ Last: _____

SSN: ___-_____-_____ Date of Birth: ____/____/_____ Gender: ☐ Male ☐ Female

Phone: (H) _____ (W) _____ (C) _____

Race: _____ Emergency Contact Person: _____ Number: _____

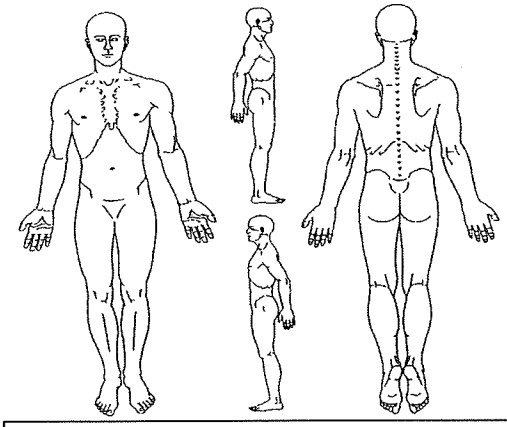
Chief Complaint and Present Illness

Chief Complaint: _____

If symptoms include Pain, check the boxes that best describe: ☐Aching ☐Boring ☐Burning ☐Cramping ☐Crushing ☐Constricting ☐Deep ☐Dull ☐Gnawing ☐Heavy ☐Knife Like ☐Lancinating ☐Piercing ☐Pounding ☐Pressure Like ☐Sharp ☐Shooting ☐Stabbing ☐Tearing ☐Tender ☐Throbbing ☐Tight ☐Other _____

Date or Time Since Symptoms Began: _____

Location of Symptoms: _____
Please mark all areas of symptoms on the diagram



Onset manner of symptoms: ☐Gradual ☐Sudden ☐Injury

Frequency of Symptoms: _____
☐Rare ☐Occasional ☐Intermittent ☐Frequent ☐Constant

Severity of Pain: ☐Minimal ☐Mild ☐Moderate ☐Severe

How long do your symptoms usually last:_____

Rate your pain on a scale of 1-10 with 10 being the worst:

How did symptoms start: _____

How have symptoms progressed: ☐Improved ☐Unchanged ☐Getting Worse

What brings on symptoms: _____ What makes symptoms worse: _____

What relieves symptoms: _____

Medications

Please list all medications that you are currently taking, **both prescription and over the counter**

Medication Name	Dosage	Frequency	Who Prescribed Medication

Past Medical History

Please provide a list and history of all past medical conditions: Ex; Asthma, Diabetes, High blood pressure etc

_____

_____

Provide a complete list of all illnesses, injuries, surgeries, and hospitalization. (Use back of page if necessary)

List Illnesses, Surgeries, and Hospitalizations	Date	Treatment

Check any childhood diseases that you have had:
☐Chicken Pox ☐Measles ☐Mumps ☐Polio ☐Rheumatic Fever ☐Rubella ☐Scarlet Fever ☐None

Have you ever had a Blood Transfusion: ☐Yes ☐No
Have you ever been exposed to a Sexually Transmitted Disease: ☐Yes ☐No If yes, list disease: _____

Allergies

List all allergies including medications and the reaction. If none, write none.

List Allergies	Reaction you had

Family History

	Status	Age	Illnesses	Cause of Death
Father	☐Living ☐Deceased ☐Unknown			
Mother	☐Living ☐Deceased ☐Unknown			

	Number	List any illnesses
Siblings		
Children		

Social History

Marital Status: ☐Single ☐Engaged ☐Married ☐Separated ☐Divorced ☐Spouse Deceased

Occupation: _____ Highest Level of Education: _____

Tobacco Use: ☐Never ☐Current ☐Discontinued - Type: _____ Quantity: _____ Years: ___
Alcohol Use: ☐Never ☐Beer(s) ___/Week ☐Liquor __/Week ☐Wine__/Week ☐Recovering Alcoholic
Caffeine: ___ Coffee ___ Tea ___Soda

Exercise: ☐Not Exercising ☐Exercising ___ Times per week - Type of exercise: _____

Illicit Drug Usage: ☐Never ☐Past History ☐Current. Please list drugs used _____
Drug/Alcohol Abuse Treatment ☐Yes ☐ No: If yes, ☐ In-Patient ☐ Out-Patient ☐ Both

Review of Systems

Please check all symptoms or illnesses that you have **currently**.

General	Eyes	Ears/Nose/Mouth/Throat	Nose
☐ Decreased Activity ☐ Changes in Appetite ☐ Chills ☐ Decreased Energy ☐ Fainting ☐ Fatigue ☐ Fever ☐ Sweating ☐ Weight Change ☐ None of above	☐ Discharge ☐ Dry ☐ Itching ☐ Drooping ☐ Redness ☐ Swelling ☐ Visual Difficulties ☐ Vision Loss ☐ None of above	☐ Congestion ☐ Discharge ☐ Earache ☐ Hearing Loss ☐ Hearing Sensitivity ☐ Pain ☐ Popping ☐ Ringing ☐ Vertigo ☐ None of Above	☐ Altered Smell ☐ Bleeding ☐ Congestion ☐ Discharge ☐ Seasonal Allergies ☐ Sinus Pain ☐ Sinus Pressure ☐ Snoring ☐ None of above
Mouth	**Throat**	**Lungs/Respiratory**	**Heart/Cardiac**
☐ Altered Sense of Taste ☐ Dry Mouth ☐ Burning Tongue ☐ Lesion ☐ Mass ☐ Sore ☐ Pain ☐ Gum Problems ☐ None of above	☐ Difficulty Swallowing ☐ Hoarseness ☐ Sore Throat ☐ Lesion ☐ Mass ☐ Cough ☐ Apnea ☐ Snoring ☐ Dryness ☐ Reflux ☐ None of above	☐ Cough ☐ Coughing Blood ☐ Shortness of Breath ☐ Sputum ☐ Wheezes ☐ None of above	☐ Chest Discomfort ☐ Chest Pain ☐ Chest Pressure ☐ Cold Hands/Feet ☐ Blue Extremities ☐ Difficulty Breathing with Exercise ☐ Extremity Swelling ☐ Heart Murmur ☐ Palpitations ☐ Increase Heart Rate ☐ None of above
Digestive/Gastrointestint	**Genitourinary**	**Female Only**	**Musculoskeletal**
☐ Abdominal Pain ☐ Bloating ☐ Constipation ☐ Diarrhea ☐ Food Intolerance ☐ Gas ☐ Heartburn ☐ Indigestion ☐ Loss of Appetite ☐ Loss of Weight ☐ Nausea ☐ Regurgitation ☐ Abnormal Stool ☐ Difficulty Swallowing ☐ Vomiting ☐ None of above	☐ Bloody Urine ☐ Frequency ☐ Bed-Wetting ☐ Incontinence ☐ Odor ☐ Pain with Urination ☐ Passing Stones ☐ Abnormal Stream ☐ Abnormal Urine Appearance ☐ Erectile Dysfunction ☐ Genital Lesion ☐ Libido Changes ☐ Prostate Problems ☐ Sexual Dysfunction ☐ None of above	Vaginal ☐ Burning ☐ Discharge ☐ Dryness ☐ Irritation ☐ Itching ☐ Lesions ☐ Painful Intercourse ☐ Premenstrual Sympt ☐ Menstrual Symptom o Irregular Bleeding o Cramps o Pain ☐ Menopausal ☐ None of above Date of last Menstrual Period:_____	Joint ☐ Inflammation ☐ Redness ☐ Pain ☐ Limited Motion ☐ Stiffness ☐ Swelling ☐ Tenderness ☐ Weakness Muscle ☐ Atrophy ☐ Cramps ☐ Pain ☐ Swelling ☐ Weakness ☐ None of above

Review of Systems Continued

Please check all symptoms or illnesses that you have **currently**.

Neurological

- ☐ Blackouts
- ☐ Balance Problems
- ☐ Concentration
- ☐ Confused/Disoriented
- ☐ Coordination Loss
- ☐ Drowsiness
- ☐ Dizziness
- ☐ Fainting
- ☐ Gait Abnormality
- ☐ Headache
- ☐ Lightheadedness
- ☐ Loss of Consciousness
- ☐ Loss of Sensation
- ☐ Loss of Memory
- ☐ Muscle Weakness
- ☐ Paralysis
- ☐ Seizures
- ☐ Speech Changes
- ☐ Tremors
- ☐ None of above

Skin

- ☐ Color Changes
- ☐ Texture Changes
- ☐ Itching
- ☐ Blisters
- ☐ Sores
- ☐ Mole Changes
- ☐ Rashes
- ☐ Hives
- ☐ Hair Changes
- ☐ Nail Changes
- ☐ None of above

Endocrine

- ☐ Hair Loss
- ☐ Voice Changes
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Excessive Urination
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ None of above

Blood/Lymphatics

- ☐ Abnormal Bleeding
- ☐ Prolonged Bleeding
- ☐ Abnormal Bruising
- ☐ Painful Lymph Nodes
- ☐ Tender Lymph Nodes
- ☐ Swollen Lymph Nodes
- ☐ None of above

Psychiatric

- ☐ Abuse Victim
- ☐ Personality Change
- ☐ Compulsiveness
- ☐ Depression
- ☐ Eating Disorder
- ☐ Irritability
- ☐ Hostility
- ☐ Hyperactive
- ☐ Nervousness
- ☐ Memory Problems
  - o Short Term Loss
  - o Long Term Loss
- ☐ Mood Swings
- ☐ Anxiety
- ☐ Sleep Problems
- ☐ Suicidal Thoughts
- ☐ None of above

By signing below I certify that that above information is true to the best of my knowledge and I consent for the provider to evaluate and recommend treatment for the condition or conditions present above.

_____ _____

Signature Date

How did you find out about our office? _____

Palmetto
Spine & Pain Care Consultants

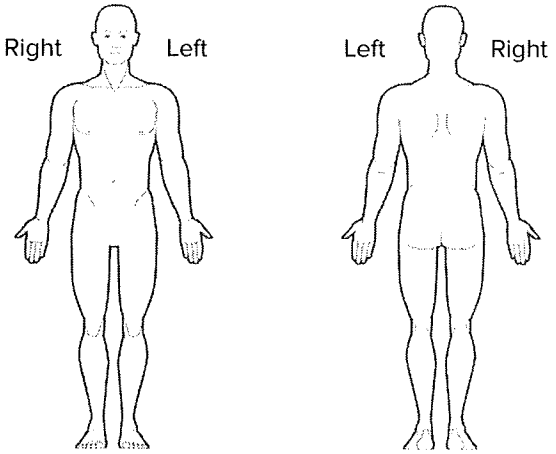
Brief Pain Inventory

Name: _____ _____ _____ **Date:** _____/_____/_____ **Time:** _____
Last First Middle Initial

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

   ☐ **Yes** ☐ **No**

2. On the diagram, shade in the areas where you feel pain. Put an **X** on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its **WORST** in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have **RIGHT NOW.**

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

7. What treatments or medications are you receiving for your pain?

   _____

   _____

8. In the last 24 hours how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much **RELIEF** you have received.

0%	10	20	30	40	50	60	70	80	90	100%
No Relief										Complete Relief

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

   A. **General Activity**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

   B. **Mood**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

   C. **Walking Ability**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

   D. **Normal Work** (both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

   E. **Relations with other people**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

   F. **Sleep**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

   G. **Enjoyment of Life**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

In addition to completing the Brief Pain Inventory, to help your doctor better manage your pain, please tell us:

What does the pain feel like? Circle the words that describe your pain.

aching	throbbing	shooting
stabbing	gnawing	pricing
sharp	tender	burning
exhausting	tiring	penetrating
nagging	numb	miserable
unbearable	dull	radiating
squeezing	cramping	deep

How long have you had this pain? (Circle one)

less than a week	1 to 2 weeks
2 to 4 weeks	more than a month

What kinds of things make your pain feel better (for example, heat, medicine, rest)?

_____

_____

What kinds of things make your pain worse (for example, walking, standing, lifting)?

_____

_____

Do you have any other symptoms? (Circle any that apply)

nausea	vomiting
constipation	diarrhea
lack of appetite	indigestion
difficulty sleeping	feeling drowsy
nightmares	dizziness
tiredness	itching
urinary problems	sweating
weakness	headaches

Talking About Your Pain

It's important to remember that each person's pain is different. The pain that you experience can't be compared to another person's pain. ONLY YOU know how and when you hurt, and how the pain affects your life.

It is important to describe what you are feeling to those who are trained to help you. Don't be embarrassed to talk to your doctor, nurse, or pharmacist. They need to know as much as possible about your pain in order to develop the best plan to control it. The questions on this form can help you describe your pain.

Why Is Pain Relief So Important?

Proper treatments for pain is not only a matter of comfort. Unrelieved pain can lead to nausea, loss of sleep, depression, appetite, weakness, and other problems. Pain can also affect your life at home and at work. Relieving your pain means that you can continue to do the day-to-day things that are important to you.

Most Pain Can Be Controlled

It is important to know that most pain CAN be relieved. Your doctor will work with you to find the treatment that may be best for your pain.

The key to effective pain controls is to take the RIGHT AMOUNT, of the RIGHT MEDICINE, at the RIGHT TIME. You should take your pain medicine on a regular schedule, as your doctor, nurse, or pharmacist tells you. Don't wait until the pain becomes severe. Pain is easier to control when it is mild than when it has reached full force.

If your pain medicine wears off too soon, is not relieving the pain, or causes problems with side effects, you should call your doctor because you may need to have your treatment plan changed.

Comments: (write down any questions or information you need to share with you doctor, nurse, or pharmacist about your pain.

_____

_____

_____

_____