



Patient Name: _____
Date of Birth: ____/____/____
Date of Service: ____/____/____

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PATIENT HISTORY FORM

Please have your History Form completed PRIOR to your visit. Your appointment may be rescheduled if the form is not completed.

Patient:

Last Name _____ First Name _____ Middle Initial ____
Date of Birth ____/____/____

Reason for today's visit: _____

Primary Care Physician (PCP) _____

Referring Physician (RP) *Complete only if different from PCP* _____

Please list other physician specialists you have seen for pain in the last five years?

Work History:

Do you work? Yes No Are you on disability? Yes No

If you are currently employed please complete the following:

Employer: _____

What is your job? _____

Did an injury cause your pain? Yes No

If yes, how long has the pain bothered you and describe the injury. Please also list the date of the injury including year.

Date: ____/____/____ Length of pain _____

Describe Injury: _____

Attorney Name: _____ Phone # _____ Fax # _____

Case Manager: _____ Phone # _____ Fax # _____

What other medical problems do you have?

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Do you have any allergies? Yes No If yes, please list your allergy and reaction.

Allergy	Reaction	Iodine
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	Tape <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	X-Ray <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	

Social History:

Marital Status: Single Divorced Married Who lives with you? _____
Do you smoke? Yes No How many packs per day? _____ For how long? _____
Do you drink alcohol? Yes No Daily? Yes No # of drinks per sitting? _____
Have you ever had any problems with misuse of prescription medications, alcohol, street drugs or any other substances? Yes No

Family History:

Do you have a family history of any medical problems? Yes No
If yes, what? _____
Are your parents living? Mother Yes No Father Yes No
If no, age and cause of death: _____

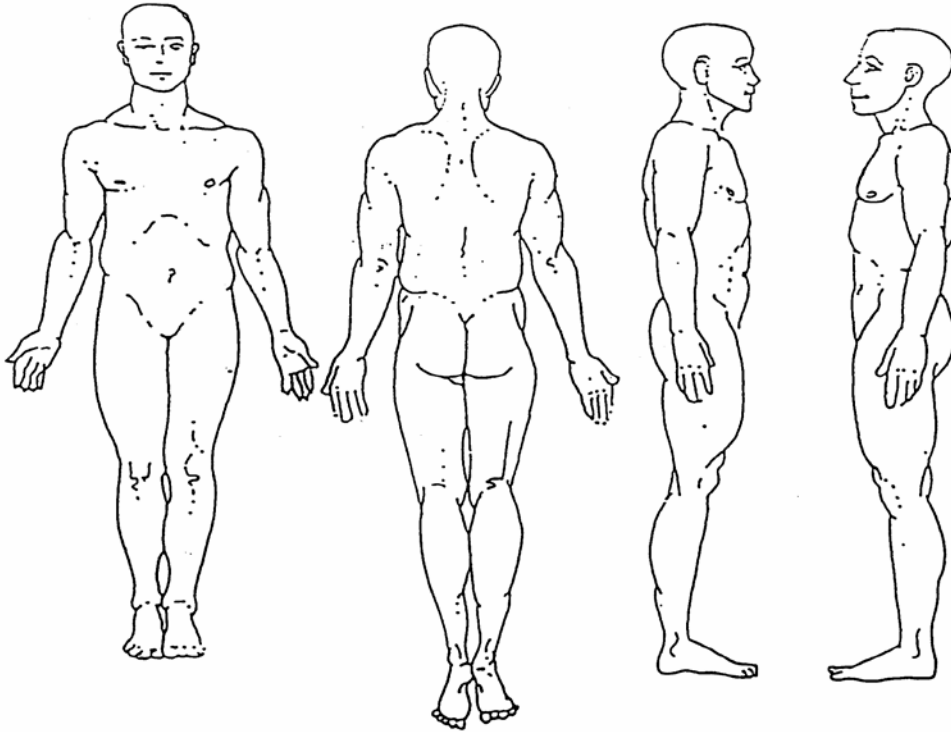
Circle *all* words that describe your pain. (*Circle more than one, if necessary*):

- | | | |
|-----------|-------------|-----------------|
| Aching | Sharp | Exhausting |
| Throbbing | Tender | Tiring |
| Shooting | Hot-Burning | Sickening |
| Stabbing | Cramping | Fearful |
| Gnawing | Heavy | Punishing-Cruel |
| | Splitting | |

Other (please list): _____

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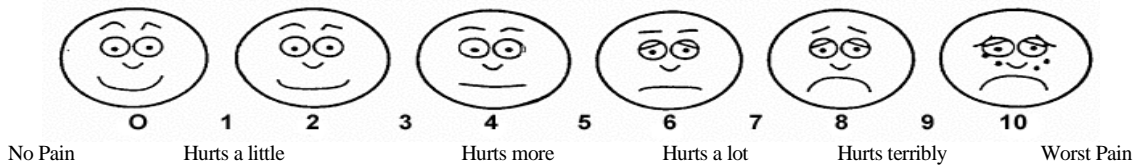
Please fill in the pain diagram below to show us where your pain is. Mark the areas below with “O”s for severe and “X”s where your pain is the worst.



Pain Scale Instructions:

Pain is a *subjective* experience. Please use this scale to help us understand the severity of your pain. (Circle one)

- 1-4 Pain that does not prevent you from participating and completing daily activities.
- 5 Pain that makes you feel you need medication, but does not force you to stop your activity.
- 6-7 Pain that is severe enough to stop any task and necessitates immediate medication.
- 8-9 Pain so severe and debilitating that someone else has to get your medications for you.
- 10 Absolutely the worst pain. You are completely disabled.



Which face/number shows how much you hurt **now**? _____
 Which face/number best describes your pain at its **worst** in the last 24 hrs? _____
 Which face/number best describes your pain at its **least** in the last 24 hrs? _____
 Which face/number best describes how much you hurt on **average**? _____

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Circle the *one* number in each category that best describes how, during the past 24hrs, 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 (include 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

What is your goal for pain control?

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PAIN MEDICATION SIDE EFFECTS:

The following *effects* can occur in people taking pain medication. If you **are now** having any of these from your medication, place an “X” next to the level of intensity: **Mild, Moderate, or Severe.**

Nausea..... Mild Moderate Severe

Poor Sex Drive..... Mild Moderate Severe

Itching..... Mild Moderate Severe

Sweats..... Mild Moderate Severe

Rash..... Mild Moderate Severe

Constipation..... Mild Moderate Severe

Flushing..... Mild Moderate Severe

New Headache..... Mild Moderate Severe

Sweating..... Mild Moderate Severe

Increase Joint Pain..... Mild Moderate Severe

Feeling drunk..... Mild Moderate Severe

Difficulty Urinating..... Mild Moderate Severe

Dizziness..... Mild Moderate Severe

Shakiness..... Mild Moderate Severe

Poor Concentration..... Mild Moderate Severe

Increase Tiredness..... Mild Moderate Severe

New/Increase of leg/foot swelling... Mild Moderate Severe

FOR PEOPLE USING THE DURAGESIC PATCH:

Skin irritation at the site of the medication patch..... Mild Moderate Severe

Medication patches do not stick well..... Mild Moderate Severe