Patient Name _____ DOB _____

200 S. 5th St.
Salina Ks 67401
Phone 785-827-2238 Fax 785-827-1684
785-822-0915

PAIN DESCRIPTION AND HISTORY-page 1 of 4

WHERE ARE YOUR WORST 2 PAIN COMPLAINTS TODAY?

_____

PLEASE RATE YOUR AVERAGE PAIN OVER THE PAST MONTH ON A SCALE FROM 1-10 FOR EACH:

_____

Pain Score (0-10)

Now _____ At rest _____ With activity _____

When did your pain start? _____

Description of pain: _____

HOW DOES YOUR PAIN FEEL?

___ Sharp ___ Dull ___ Aching ___ Burning

___ Cramping ___ Pressure ___ Stabbing

___ Electrical Shock ___ Shooting ___ Numbness

___ Tingling ___ Other _____

___ Constant ___ Intermittent

NUMBNESS OR TINGLING LOCATION? _____

WHAT CAUSED YOUR PAIN?

___ Injury at work ___ Injury at home

___ Following an illness ___ Following a surgery

___ Started all of a sudden – no cause

___ Came on gradually/gradually worsened

___ Other _____

WHICH TREATMENTS HAVE YOUR TRIED?

___ Biofeedback ___ Herbal Remedies

___ Yoga ___ Massage

___ Surgery ___ TENS unit

___ Acupuncture ___ Water Therapy

___ Spinal Cord Stimulator Surgery

___ Medications ___ Ice Pack

___ Heating Pad ___ Exercise program

___ Physical Therapy ___ Implantable Device

___ Comprehensive Pain Program

___ Injection: When? _____

__ Other _____

WHAT MAKES YOUR PAIN WORSE?

___ Sitting ___ Standing

___ Coughing/Sneezing ___ Walking

___ Lying on stomach ___ Sleeping

___ Weather changes ___ Driving/Travel

___ Bending/twisting

___ Other: _____

_____

WHAT MAKES THE PAIN BETTER?

_____

WHAT PHARMACY DO YOU USE? _____

HAVE YOU TAKEN ANY ANTICOAGULANT (BLOOD THINNER OR ASPIRIN) MEDICINE IN THE LAST 3 MONTHS?

___ Yes ___ No *If yes*, Name of drugs: _____ For What? _____

Please list all prescription and/or over the counter medications you take: (Please attach additional sheet if needed)

Name of Medicine	Dose of Medicine/Frequency	Prescribing Physician

Patient Name _____ DOB _____

ANY ALLERGIES TO MEDICATION INCLUDING OVER-THE-COUNTER MEDICATIONS AND HERBAL SUPPLEMENTS:

___ No Allergies

ALLERGY	TYPE OF REACTION	ALLERGY	TYPE OF REACTION
_____	_____	_____	_____
_____	_____	_____	_____

LIST SURGERIES (INCLUDE DENTAL) INJURIES, HOSPITALIZATIONS & PROCEDURES NOT LISTED ON PREVIOUS PAGES:

Date: _____ Procedure: _____

Date: _____ Procedure: _____

Date: _____ Procedure: _____

Date: _____ Procedure: _____

MEDICAL HISTORY

LUNGS AND RESPIRATORY: ___ **None**

___ Emphysema ___ Cough/Cold

___ Asthma/Wheezing ___ Sleep Apnea

___ Pneumonia

___ Other _____

HEART AND VASCULAR: ___ **None**

___ Heart Failure ___ Angina/Chest pain

___ High Blood Pressure ___ Pacemaker

___ Irregular Heart Beat ___ Valve Disease

___ High Cholesterol

GENITO/URINARY: ___ **None**

___ Kidney Stones ___ Kidney, Renal or

___ Urinary Catheter Urinary Tract Disease

___ Dialysis: last date: _____

___ Other _____

GASTROINTESTINAL: ___ **None**

___ Rectal Bleeding ___ Liver Disease

___ Ulcers ___ Nausea/Vomiting

___ Pancreatitis

___ Other _____

PSYCHOLOGIC: ___ **None**

___ Depression ___ Sleep Disturbance

___ Anxiety ___ Suicidal Thoughts

HEMATOLOGIC: ___ **None**

___ Bruising ___ Hepatitis

___ Blood clotting abnormalities

___ Easy Bleeding ___ Anemia

___ Other: _____

NERVOUS SYSTEM: ___ **None**

___Stroke ___Dizziness

___ Numbness/weakness ___ Falls

___ Fainting spells/Blackouts ___ Head/Neck Injury

___ Seizure/Epilepsy ___ Headaches

___ Other _____

MUSCULAR-SKELETAL SYSTEM: ___ **None**

___ Muscle/Joint Pain ___ Arthritis

___ Chronic Back/Neck Trouble ___ Multiple Sclerosis

___ Unusual Muscle Weakness ___ Paralysis

___ Autoimmune Disorder ___Fibromyalgia

___ Other _____

ENDOCRINE: ___ **None**

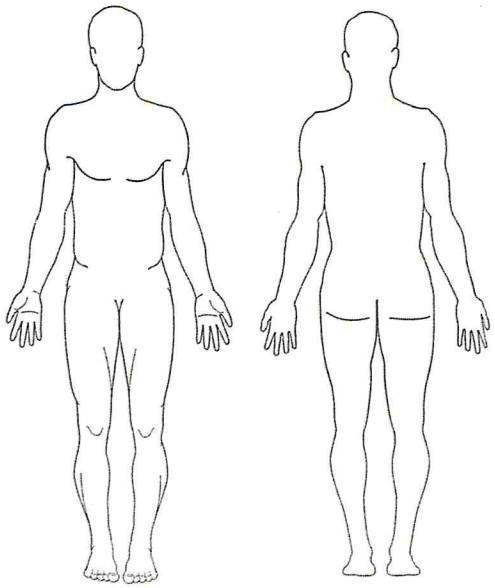
___Diabetes ___ Thyroid Problems

___ Sweats/Chills ___ Low Blood Sugar

___ Other _____

Yes	**No**	
___	___	Do you use tobacco ___ Cigarettes __ packs/day ___Cigars ___ Pipe ___ Chew (quit_____) Years used ___
___	___	Would you like to receive information about stopping?
___	___	Do you use alcohol? How much? _____ Last drink _____ Recovering Alcoholic _____
___	___	Marijuana or other street drugs? What_____ How often _____

PLEASE FILL IN THE DIAGRAM BELOW INDICATING THE TYPE OF PAIN/SENSATIONS YOU ARE HAVING AND THE LOCATION ON YOUR BODY:



(PATIENTS PLEASE COMPLETE)

Review of Systems: **Please circle all current problems:**

General: fever / chills / other _____

Eyes: blurring / double vision / other _____

Ear, nose and throat: ear pain / nasal congestion / other _____

Lungs: shortness of breath / cough / other _____

Heart: chest pain / palpitations / other _____

Gastrointestinal: nausea / vomiting / other _____

Genitourinary: painful urination / new issue with loss of bladder control / other _____

Hematology: bruising tendency / bleeding tendency / other _____

Endocrine: excessive thirst / excessive urination / other _____

Immunologic: recurrent fevers / recurrent infections / other infections _____

Musculoskeletal: back pain / neck pain / joint pain / muscle pain / other _____

Integumentary: rash / abrasions / other _____

Neurologic: confusion / numbness / other _____

Psychiatric: anxiety / depression / other _____

Advanced Care Plan

Do you have an Advanced Care Plan in place? No / Yes

If Yes, please circle all that apply:

DNR Order / Living Will / DPOA / Healthcare Proxy / Oral Statement / Other: _____

Patient Name _____ DOB _____

FOR OFFICE USE ONLY BELOW THIS LINE.

History and Physical Note

Physical Exam:

General/Orientation: I A&O x3 I No acute distress I other _____

Extremities: I No cyanosis/clubbing I No edema I other _____

Respiratory: I Clear to auscultation I Unlabored I other _____

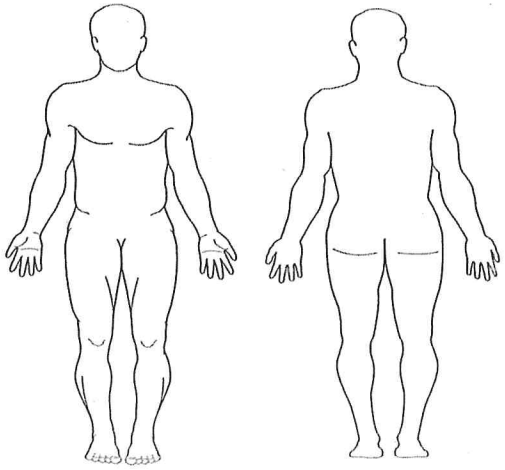
Cardiac: I Regular rate and rhythm I No murmur I other _____

Abdominal: I Nondistended I soft I other_____

Skin: I Clean I Dry I Intact I other _____

Musculoskeletal: _____

Neuro: _____



Anesthesia Plan: (✓) one: _____Local anesthesia _____Mild/Moderate Sedation (ASA Classification :_____)

Assessment/Plan: _____

Follow up: _____

Orders: _____

The patient is an appropriate candidate to undergo the planned procedure and selected anesthesia in the ambulatory setting: I Yes I No

Review of systems on back page reviewed: ____Yes _____No

Physician Signature _____ Date (m/d/y) _____ /_____ /_____ Time _____

Post Procedure Pain Level: _____ (Universal Pain Assessment Tool 0-10 scale)