KANSAS PAIN MANAGEMENT
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PATIENT HISTORY FORM (PAGE 1)

TODAY'S DATE		PATIENT FIRST NAME	
DATE OF BIRTH		PATIENT LAST NAME	

PAST MEDICAL HISTORY
(Please Circle ALL That Apply)

DIABETES	COPD	STOMACH ULCERS
HYPERTENSION	ASTHMA	SEIZURES
CARDIAC DISEASE	OTHER LUNG DISEASE	CANCER
PREVIOUS HEART ATTACK	PANCREATIC DISEASE	HEPATITIS
CONGESTIVE HEART FAILURE	KIDNEY DISEASE	CIRRHOSIS
STROKE	GERD	OTHER

SURGICAL HISTORY
(Please List Any Operations or Surgeries You Have Had In The Past)

TYPE OF SURGERY		YEAR	
TYPE OF SURGERY		YEAR	
TYPE OF SURGERY		YEAR	
TYPE OF SURGERY		YEAR	
TYPE OF SURGERY		YEAR	

FAMILY HISTORY
(Please List Any Medical Conditions That Run In You Family, Including Chronic Pain, Back.Neck Problems and/or Substance Use)

MEDICAL CONDITION		FAMILY RELATION	
MEDICAL CONDITION		FAMILY RELATION	
MEDICAL CONDITION		FAMILY RELATION	
MEDICAL CONDITION		FAMILY RELATION	
MEDICAL CONDITION		FAMILY RELATION	

SOCIAL HISTORY

WHAT IS YOUR CURRENT MARITAL STATUS?	SINGLE-NEVER MARRIED	MARRIED	DIVORCED	WIDOWED	SEPARATED			
WITH WHOM DO YOU LIVE?	LIVE ALONE	SPOUSE	PARENTS	IN-LAWS	WITH CHILDREN	WITH RELATIVES	WITH SIBLING(S)	OTHER
HOW FAR DID YOU GET IN SCHOOL? (Please Circle One)	< 8TH GRADE	<12TH GRADE	COMPLETED HIGHSCHOOL	TECH SCHOOL	COMPLETED TECH SCHOOL	SOME COLLEGE	COMPLETED COLLEGE	ADVANCED DEGREE
DO YOU DRINK ALCOHOLIC BEVERAGES?	YES	NO	HOW MUCH DO YOU CONSUME?					
IF YES, HOW OFTEN? (Please Circle)	< ONCE/WEEK	> ONCE/WEEK	SEVERAL TIMES/WEEK	DAILY	I AM A HEAVY DRINKER			
HAVE YOU EVER BEEN TREATED FOR ALCOHOL ABUSE?	YES	NO	IF YES, WHEN? (Please Describe)					
HAVE YOU EVER USED ILLICIT DRUGS?	YES	NO	DO YOU CURRENTLY USE ILLICIT DRUGS?	YES	NO			
IF YES, WHAT DRUG(S)			LAST TIME USED?					
DO YOU CURRENTLY SMOKE CIGARETTES?	YES	NO	IF NO, WERE YOU A FORMER SMOKER?	YES	NO			
WHEN DID YOU QUIT FOR GOOD?			IF YES, HOW MANY PACKS/DAY?		FOR HOW MANY YEARS?			
WHAT DO YOU DO FOR EXERCISE?	NOTHING	WALKING	JOGGING	SPINNING	BIKING	OTHER		
HOW OFTEN?	ONCE/MONTH	ONCE/WEEK	TWICE/WEEK	3X/WEEK	DAILY			