KANSAS PAIN MANAGEMENT
10995 QUIVIRA ROAD, OVERLAND PARK, KS 66210
Phone: 913.339.9437 Fax: 913.339.9538

PATIENT HISTORY FORM (PAGE 2)

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

WORK HISTORY

EMPLOYMENT STATUS?	FT PT RETIRED STUDENT HOMEMAKER UNEMPLOYED UNABLE TO WORK
WHAT IS (WAS) YOUR OCCUPATION?	
WHICH OF THE FOLLOWING ARE REGULAR REQUIREMENTS OF YOU JOB? (Please Circle ALL That Apply)	LIFTING < 30lbs LIFTING > 30lbs FREQUENT BENDING, STOOPING, TWISTING COMPUTER WORK SITTING FOR > 1 HR AT A TIME STANDING FOR > 1 HR AT A TIME
OTHER PHYSICAL REQUIREMENTS (Please Describe)	
HOW MUCH WORK HAVE YOU MISSED AS A RESULT OF YOUR PAIN PROBLEM?	NONE _____ DAYS _____ WEEKS _____ MONTHS OTHER
PLEASE DESCRIBE ANY OTHER ISSUES RELATED TO YOUR PAIN THAT HAS NOT BEEN COVERED BY THE ABOVE QUESTIONS:	

PATIENT ALLERGIES

**** PLEASE LIST ALL ALLEGIES TO MEDICATIONS OR OTHER DRUGS ****

NAME OF MEDICATION OR DRUG		ADVERSE REACTION		LAST OCCURRED		
NAME OF MEDICATION OR DRUG		ADVERSE REACTION		LAST OCCURRED		
NAME OF MEDICATION OR DRUG		ADVERSE REACTION		LAST OCCURRED		
ARE YOU ALLERGIC TO IODINE CONTRAST DYE (IVP DYE)?	YES NO	IF YES, WHAT TYPE OF REACTION DID YOU HAVE?		LAST OCCURRED		
ARE YOU ALLERGIC TO ASPIRIN ?	YES NO	IF YES, WHAT TYPE OF REACTION DID YOU HAVE?		LAST OCCURRED		
ARE YOU ALLERGIC TO ANTI-INFLAMMATORY MEDICATIONS (e.g.	YES NO	IF YES, WHAT TYPE OF REACTION DID YOU HAVE?		LAST OCCURRED		
ARE YOU ALLERGIC TO LATEX?	YES NO	IF YES, WHAT TYPE OF REACTION DID YOU HAVE?		LAST OCCURRED		
ANY OTHER ALLERGIES THAT SHOULD BE NOTED NOT MENTIONED ABOVE?		IF YES, WHAT TYPE OF REACTION DID YOU HAVE?		LAST OCCURRED		

CURRENT MEDICATIONS

LIST MEDICATIONS TAKEN FOR PAIN

NAME OF MEDICATION OR DRUG		DOSAGE		FREQUENCY		PRESCRIBED BY	
NAME OF MEDICATION OR DRUG		DOSAGE		FREQUENCY		PRESCRIBED BY	
NAME OF MEDICATION OR DRUG		DOSAGE		FREQUENCY		PRESCRIBED BY	

LIST OF OTHER MEDICATIONS TAKEN

NAME OF MEDICATION OR DRUG		DOSAGE		FREQUENCY		PRESCRIBED BY	
NAME OF MEDICATION OR DRUG		DOSAGE		FREQUENCY		PRESCRIBED BY	
NAME OF MEDICATION OR DRUG		DOSAGE		FREQUENCY		PRESCRIBED BY	

GENERAL MEDICATION QUESTIONS APPLICABLE TO TODAY'S VISIT

DO YOU TAKE ASPIRIN?	YES	NO	IF YES, WHEN WAS YOUR LAST DOSE IN THE LAST 24 HRS?		
DO YOU TAKE COUMADIN, PLAVIX, PLETAL, AGGRENOX, TICLID OR A BLOOD THINNER?				YES	NO
IF YES, WHEN WAS YOUR LAST DOSE IN THE LAST 24 HRS?					
IF YES, WHO IS THE PRESCRIBING PHYSICIAN?					
IF YES, DO YOU HAVE WRITTEN PERMISSION FROM PRESCRIBING PHYSICIAN TO DISCONTINUE FOR ANY LENGTH OF TIME?				YES	NO

**** YOU MUST HAVE WRITTEN PERMISSION ON FILE FROM THE PRESCRIBING PHYSICIAN IN ORDER TO STOP THIS MEDICATION ****

DO YOU TAKE ANY HERBAL MEDICATIONS?	YES	NO	IF YES, LIST MEDICATIONS:	
DO YOU TAKE VITAMIN E?	YES	NO	IF YES, WHEN WAS YOUR LAST DOSE?	