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

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		

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PATIENT HISTORY FORM (PAGE 2)

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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?	

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PATIENT HISTORY FORM (PAGE 3)

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HEALTH ASSESSMENT

GENERAL HEALTH	NONE WEIGHT LOSS WEIGHT GAIN FATIGUE LOSS OF APPETITE
FEMALES ONLY PREGNANT?	YES NO
EYES	NONE EYE PAIN DOUBLE VISION SEVERE REDNESS LOSS OF VISION
EARS	NONE EAR PAIN HEARING LOSS RINGING IN EARS DIZZINESS
NOSE	NONE RUNNY NOSE NASAL CONGESTION NOSE BLEEDS SINUS PAIN/PRESSURE
MOUTH/THROAT	NONE SORE THROAT PROBLEMS SWALLOWING SORES IN MOUTH TOOTH PAIN HOARSENESS
CHEST/HEART	NONE CHEST PAIN RACING/POUNDING HEART LEG PAIN PROBLEMS BREATHING LYING DOWN LIMP W/ WALKING
RESPIRATORY	NONE COUGH WHEEZING SHORTNESS OF BREATH COUGHING UP BLOOD OR MUCUS W/ BLOOD
STOMACH	NONE HEARTBURN NAUSEA/VOMITTING ABDOMINAL PAIN VOMITING UP BLOOD
BOWELS	NONE DIARRHEA CONSTIPATION BLACK/BLOODY STOOLS UNUSUAL CHANGE IN STOOL
URINARY TRACT	NONE BLOOD IN URINE INCREASED URINATION DIFFICULTY URINATING PAIN W/ URINATION
MUSCULOSKELETAL	NONE BACK PAIN PAIN IN MUSCLES/JOINTS LIMITED RANGE OF MOTION
SKIN	NONE RASH REDNESS SORES IN MOUTH CHANGING MOLES/WARTS/LESIONS
NEUROLOGICAL	NONE SEIZURES PROBLEMS W/ COORDINATION WEAKNESS/NUMBNESS/TINGLING MEMORY/SENSORY ISSUES
ENDOCRINE	NONE UNUSUAL CHANGES IN SKIN/HAIR INCREASED SENSITIVITY TO TEMPERATURE CHANGES
BLOOD	NONE BLEEDING GUMS SWOLLEN HANDS/FEET SWOLLEN GLANDS FREQUENT NOSE BLEEDS UNUSUAL BRUISING
IMMUNE	NONE SNEEZING ITCHING EYES FREQUENT SINUS, EAR OR RESPIRATORY INFECTIONS
MENTAL HEALTH	NONE MOOD SWINGS EMOTIONAL CHANGES THOUGHTS OF HURTING SELF OR OTHERS

I CERTIFY THAT I HAVE ANSWERED ALL OF THE ABOVE QUESTIONS TRUTHFULLY AND TO THE BEST OF MY ABILITY.

PATIENT PRINTED NAME			
PATIENT SIGNATURE		**DATE**	