

PAIN QUESTIONNAIRE MIDWEST PAIN CENTER

Name _____

Date: _____

Past Medical History:

Patient's Age: _____

What medical problems do you have? Check the diseases

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> COPD-Emphysema |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis (DJD, Rheumatoid) | <input type="checkbox"/> Ulcers/GERD | <input type="checkbox"/> Stroke/CVA |
| | <input type="checkbox"/> Abnormal Heart Beat | | |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Heart (angina, heart attack) | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Abnormal Heart Beat | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Anemia |
| | <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Low Thyroid |

List all medications, including over the counter: (continue on if necessary)

medication	dosage	frequency	medication	dosage	frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

List any operations you have had and the dates:

- | | |
|----------|----------|
| A. _____ | B. _____ |
| C. _____ | D. _____ |

List any severe accidents or trauma you have had and the dates:

- | | |
|----------|----------|
| A. _____ | B. _____ |
|----------|----------|

List any psychiatric or psychological (depression/anxiety) care you have had or have now:

- | | |
|----------|----------|
| A. _____ | B. _____ |
|----------|----------|

Drug Allergies: Yes No If so, please list: _____

Latex Allergy: Yes No

Social History:

- Marital Status: married widowed divorced single
- Do you smoke? No YesHow many packs a day? _____ How many years? _____
- Do you drink? No YesHow may drinks per day _____ How many years? _____
- Do you currently use illegal drugs? No Yes If yes what? _____
- How many years? _____
- Do you use alcohol or illegal drugs to treat your pain? No Yes

Family History:

List any chronic illness your mother or father has?

Mother _____	Father _____
_____	_____