Orthopedic Associates of Dutchess County, P.C.
Pain Questionnaire

The purpose of this questionnaire is to obtain a complete assessment of you and your pain problems. This is a long questionnaire because pain is a very complex problem that affects all aspect of your life. We are trying to evaluate how the pain has affected your life so that we can make the best recommendation possible to assist you in your recovery. This record is confidential and no one can see it without your permission.

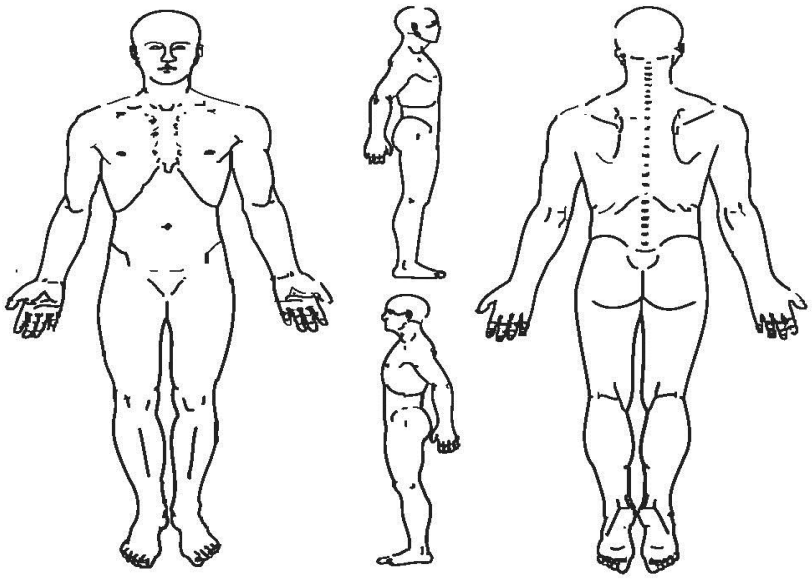
Patient's Name:_____ D.O.B._____Age_____
Acct#:_____ Date:_____
Signature/Relationship of person completing this form:_____
Patient Address:_____ Phone(home):_____
_____

Referring Physician's name and address: _____
Phone#

Are you currently receiving or in the process of receiving worker's compensation related to your problem? YES NO

Pain Diagram

Pain: + + + Numbness: - - - Tingling: x x x



Pain History (Circle one that applies)	**Pain Intensity (Circle the one that applies)**
Throbbing, Shooting, Stabbing, Sharp, Cramping, Gnawing, Hot burning, Aching, Numbness, Tingling, Dull, Pulling	**0 1 2 3 4 5 6 7 8 9 10** 0= No Pain 5=Moderate Pain 10=Worst Pain Number your pain when it is worst: _____ Number your pain when it is least:_____ Number your pain on average: _____

When did the pain began? _____
How did your pain begin?_____
Briefly describe the circumstance when your pain began:_____
_____
In general, when is your pain the worst?
Morning _____ Afternoon_____Evening _____ Night_____ No pattern to the pain____
How often do you have the pain?
Constantly (100% of time) _____ Nearly constantly(60-90% of time)_____
Intermittent (30-60% of time) _____ Occasionally (less than 30% of time) _____

Please circle when your pain is felt:
Worse: Walking Lifting Bending Lying Weather changes Standing Other:_____
Better: Heat Ice Rest Lying Weather changes Standing Medication:_____

Prior Treatments (Check all that apply)

	Helpful	Not Helpful
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Diagnostic Procedure done

Diagnostic Test	**Body part evaluated**	**Date**
Plain X-Rays		
MRI		
CT Scan		
EMG		
Bone Scan		
Discogram		
Myelogram		

Patient's Name:_____ D.O.B._____Age_____Acct#:_____Date:_____

Past Medical History

☐Heart Problems_____
☐Hypertension_____
☐Circulation Problems_____
☐Diabetes_____
☐Kidney/Bladder Problems_____
☐Liver Problems_____
☐Cancer_____
☐Blood Disorders_____
☐Lung Problems/Asthma_____
☐Intestinal Problems/Ulcers_____
☐Blackouts/Falls_____
☐Other_____
☐Any medical Devices implanted in your body?_____
(i.e., pacemaker, portacath, pump, rods, prosthesis, etc.)

Past Surgical History

Name of Surgery	Date

Please list <u>all medication</u> and dosages you are currently taking. PLEASE DO NOT OMIT any blood thinners you may be taking; i.e., Coumadin, Lovenox, Heparin, Plavix, Aggranox, etc.

_____
_____
_____
_____

Please list all drug allergies

_____
_____
_____

Social History

Significant other: _____ Relationship: _____ Phone: _____
Do you take care of other family members:_____
Previous/Current Occupation:_____
Are you currently working? YES NO If not, why?_____
Do you have any legal issues that are current or pending related to your current medical problem? YES NO
If yes, please specify_____
Do you smoke? YES NO If yes, how many per day?_____
Recreational drug use? YES NO
Alcohol use? YES NO If yes, how many per day/week?_____

Patient's Name:_____ D.O.B._____ Age_____Acct#:_____ Date:_____

Family History

Do you have a family history of the following? Please circle the ones that apply.

Pain Arthritis Cancer Psychological problems Bleeding disorder Other_____

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Patient's review of systems (Circle the ones that apply to you)

Eyes: Eyeglasses Contacts Glaucoma
Skin: Rashes Dermatitis Psoriasis Eczema
Ear/Nose Throat: Deafness Allergies Sinus Trouble Nosebleeds Chronic Sinus Infections Difficulty Swallowing
Neurologic: Stroke Dizziness Numbness Fainting Seizure Multiple Sclerosis Parkinson's Blackout/Falls
Infectious Disease: HIV Infection Hepatitis Lyme Disease Post TB Test
Heart and Cardiovascular: Chest Pain Heart Disease Blood Clots Rheumatic Fever Heart Attack Hypertension Arrhythmia Murmurs Palpitations Hypotension Varicose Veins PE Circulation Problems
Endocrine: Diabetes Mellitus Thyroid Disease
Genitourinary: Bladder Disorders Infections of a Kidney Dysuria Renal Disease Kidney Stone Analysis Nocturia Bladder Incontinence Frequent Urination Prostate Problem
Pulmonary/Respiratory: Asthma Emphysema Bronchitis Pneumonia Wheezing SOB Apnea
Hematological/Lymphatic: Lymphedema Easy Bleeding Easy Bruising Anemia Blood Transfusion Hematologic Disorder Sickle Cell
Psychologic: Depression Anxiety Bipolar Disorder
Gastrointestinal: Ulcer Nausea Constipation Liver Disease Reflux Vomiting Bloody/Black Stool Jaundice Crohn's Diarrhea Abdominal Pain
Constitutional: Fever Anorexia Night Sweats Chills Weight Loss Fatigue
Oncologic: Breast Cancer Kidney Cancer Lung Cancer Colon Cancer Liver Cancer Prostate Cancer Skin Cancer
Musculoskeletal: Rheumatoid Back Pain Slipped Disc Joint Pain