Pain Management of North Idaho
Patient Information

Patient Name: _____Date of Birth:_____Date:_____

What area of pain are you seeking treatment for today?_____

What pharmacy do you use?_____

Medication Name:	Strength:	Direction:

Or provide list of medications

Do you take any supplements? _____yes _____no

Allergies:	Reaction:

Past Medical History:

Please check the box if you have/had this medical condition:

Anemia		**Colon cancer**		**Hyperlipidemia**		**Peripheral never disorder**	
Angina		**Congestion heart failure**		**Hypertension**		**Renal disease**	
Arrhythmia		**COPD**		**Kidney Failure**		**Rheumatoid arthritis**	
Atrial Fibrillation		**Coronary Artery Disease**		**Liver Disease**		**Seizure disorder**	
Blood clots		**Diabetes**		**Lung cancer**		**Spinal cord tumor**	
Brain tumor		**Fibromyalgia**		**Migraines**		**Thyroid disease**	
Cerebral accident		**Hepatitis C**		**Multiple sclerosis**		**Tremor**	
Cirrhosis		**HIV/AIDS**		**Parkinson's disease**		**Breast Cancer**	

Other not listed history:_____

Patient Name: _____Date of Birth:_____Date:_____

Past Surgical History:

Please check the box if you have/had this surgery or condition:

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Anesthesia Reaction		**Carpal Tunnel release**		**Muscle biopsy**		**Breast reduction**	
Aneurysm clipping		**Cataract extraction**		**ORIF**		**Other joint replacement**	
Angioplasty with stent		**Cerebral shunt**		**Pacemaker**		**Other:**	
Angioplasty		**Colectomy**		**Small bowel resection**		**Other:**	
Appendectomy		**Colostomy**		**Spinal infusion pump**		**Other:**	
Arthroscopy knee		**Gastric Bypass**		**Thyroidectomy**		**Other:**	
Back surgery		**Hernia repair**		**Tonsillectomy**		**Other:**	
CABG		**Hip replacement**		**Mastectomy**		**Other:**	
Carotid endarterectomy		**Knee replacement**		**Myomectomy**		**Other:**	

Please list any significant family history:

Diagnosis	Mother	Father	Sister	Brother	Family history
Alcoholic					
Heart disease					
Cancer					
Depression					
Diabetes					
Fibromyalgia					
High Blood pressure					
Mental illness					
Substance abuse					
Other:					
Other:					

<u>Social History:</u>
Your occupation:_____
Marital status: Married_____ Divorced_____ Single_____ Widowed/Widower_____
Smoking history: Current_____ Former_____ Never_____
Drink alcohol: Daily _____ Weekly_____ Never_____ Socially_____ How much?____
Do you use illicit drugs? Yes_____ No_____ Formerly_____
Have you ever had treatment for alcohol/drug abuse: Yes_____ No_____
Do you have a history of: Psychiatric illness_____ Suicidal thoughts_____ Homicidal thoughts_____
Do you see a psychiatrist/therapist: Yes_____ No_____ Name:_____