Pain Institute of Southern Arizona

Appointment Scheduling: (520) 999-9000
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Fax: (520) 795-9953
www.pisapain.com

Patient Health History

Directions: If filling out the form on your computer, save the file and then attach the form to an email and send to patientforms@pisapain.com. If filling out the form on your phone, forward as an email (using the icon) and email to: patientforms@pisapain.com. You can also print the forms to write the answers, then scan or take a photo of the forms and email to patientforms@pisapain.com.

Patient Name:_____ Date: _____

1. Are you allergic to any of the following?

☐ Adhesive Tape ☐ Metal ☐ Iodine ☐ Seafood ☐ Latex

2. Have you been diagnosed with any of the following problems?

☐ Anemia			
☐ Anxiety	☐ Arthritis	☐Asthma	☐ Blood Clot/DVT
☐ Bone Cancer	☐ Breast Cancer	☐ COPD	☐ CAD
☐ Depression	☐ Diabetes	☐ Epilepsy	☐ Fibromyalgia
☐ Heart Disease	☐ Hepatitis	☐ High Cholesterol	☐ High Blood Pressure
☐ HIV	☐ Lung Cancer	☐ Lupus, Skin	☐ Lupus, Systemic
☐ Lymphoma	☐ Mitral Valve Prolapse	☐ Multiple Myeloma	☐ Osteoporosis
☐ Parkinson's Disease	☐ PVD	☐ Prostate Cancer	☐ Enlarged prostate
☐ Reflux	☐ Renal Failure	☐ Rheumatoid Arthritis	☐ Sleep Apnea
☐ Stomach Ulcer	☐ Stroke	☐ Thyroid Dysfunction	☐Tuberculosis

3. Please indicate your family medical history:

	Father	Mother	Brother	Sister
Arthritis	☐	☐	☐	☐
Bleeding/Clotting Problems	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Leukemia	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Problems with anesthesia	☐	☐	☐	☐
Stroke	☐	☐	☐	☐

4. Handedness

☐ Right ☐ Left ☐ No Preference

5. Caffeine Use (Coffee, Tea, Chocolate, Cola, etc.)

☐ None ☐ 1/day ☐ 2-3/day ☐ 4+/day

6. Exercise Level (20+ minute at a time)

☐ None ☐ 1-2 times/week ☐ 3+ times/week

7. Home Living setting

☐ Alone ☐ Children ☐ Spouse ☐ Nursing Home ☐ Parents
☐ Assisted Living ☐ Roommate

Please turn over and complete the rest of your questionnaire →

8. Tobacco Use

□ None □ Cigarettes □ Cigars □ Smokeless Tobacco □ E-Cigarettes

Nicotine Consumption: □ _____ pack(s)/day (or equivalent)

9. Alcoholic Beverages (A drink equals 1 shot of liquor, 1 glass of wine, or 1 bottle/can of beer)

□ None □ Abstainer (Less than 12 drinks/year) □ Light (1-13 drinks/mo)

□ Moderate (4-14 drinks/week) □ Heavy (more than 2 drinks/day)

10. Do you use recreational or "street" drugs? □ Yes □ No

11. Do you now, or have you ever, had an addiction to drugs (If yes, please explain) □ Yes □ No

Explanation:_____

_____

12. Mark if retired □ Yes

13. Review of Body Systems

Musculoskeletal

□ Bone Deformity □ Limited joint motion □ Muscle Tenderness □ Pain in Back
□ Pain in Neck □ Painful joints □ Redness over joints □ Stiff joints
□ Stiff neck □ Swollen joints

Neurologic

□ Changes in alertness □ Headache □ lost bladder control □ Numbness
□Tingling □ Weakness

Cardiovascular

□ Black out/Fainting □ Blueish discoloration □ Chest pain □ Heart murmur
□ Irregular heartbeat □ Leg cramps when walking □ Ankle swelling

Respiratory

□ Cough □ Shortness of breath □ Wheezing

Gastrointestinal

□ Abdominal pain □ Diarrhea □ Heartburn □ Nausea □ Vomiting

Constitution

□ Chills □ Fever □ Generalized aching

Eyes

□ Blurred vision □ Double vision □ Loss of vision

Ears/Throat

□ Dizziness □ Hearing loss □ Ringing in ears □ Sore throat

Allergic/Immunologic

□ Food intolerances □ Hives □ Reaction to insect bites □ Seasonal rhinitis

Endocrine

□ Cold feeling □ Fatigue □ Hot feeling □ Frequent urination

Hematologic

□ Excessive bleeding □ Bruises easily □ Armpit mass □ Groin □ Neck mass

Integumentary/Skin

□ Nail changes □ Rash □ Ulcers