THE CENTER FOR PAIN MEDICINE
MASSACHUSETTS GENERAL HOSPITAL

Questionnaire for New Patients

Hello and welcome to The Center for Pain Medicine at Massachusetts General Hospital. We ask that you help us by providing as much information as you can regarding your current condition and ongoing treatment as well as any prior diagnostic tests and treatments that you may have had. This questionnaire is designed to step you through all areas of your past and present medical care. Please complete as much of this forma s you are able to prior to your first visit, so that we can use this information at the time of your first visit to get a complete picture of you and your overall condition. Please do not hesitate to ask any of our staff or physicians for assistance if you have any questions or concerns. We look forward to meeting you.

GENERAL INFORMATION

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Date of birth: _____ / _____ / _____

Referring Physician: _____

Address: _____

Phone: _____

Primary Care Physician (if different from referring physician):

_____

Address: _____

Phone: _____

Pharmacy: _____ Phone: _____

Address: _____

DESCRIBE YOUR PAIN SYMPTOMS

*When did your pain first start?*_____

*Where is your pain?*_____

_____

What do you think is causing your pain? _____

_____

Did your pain begin with an injury? ☐No/☐Yes:

If you were injured, did the injury occur: ☐ at work, ☐ in a motor vehicle accident, or ☐ under other circumstances? Please explain how you were injured:_____

_____

Please rate your pain on a scale from 0 (no pain) to 10 (the most severe pain you can imagine):

How severe is you pain at its WORST? _____ /10

How severe is your pain at its BEST? _____ /10

What does your pain feel like? (Check all that apply)

☐ Throbbing ☐ Shooting ☐ Stabbing ☐ Burning ☐ Sharp ☐ Tingling ☐ Numb

☐ Tender ☐ Pressure ☐ Deep ☐ Aching ☐ Cramping ☐ Heaviness

☐ Other:

_____

What is the pattern of your pain? ☐ Continuous (always present) ☐ Comes and goes ☐ Gets worse as the day goes on

What makes your pain worse? ☐ Sitting ☐ Bending ☐ Lifting ☐ Twisting ☐ Driving

☐ Coughing ☐ Sneezing ☐ Standing ☐ Walking ☐ Lying down

☐ Other, explain: _____

What makes your pain better? ☐ Rest ☐ Lying down ☐ Bending ☐ Sitting

☐ Medication ☐ Ice or heat

☐ other, specify: _____

Does your pain interfere with any of the following? (check all that apply)

☐ Sleep ☐ Daily activities ☐ Work ☐ Relationships

Does your pain make you feel: (check all that apply)

☐ Depressed ☐ Angry ☐ Frustrated ☐ Helpless/hopeless

Please check any previous treatments you have had for your current pain:

☐ Herbal remedies ☐ Physical or occupational therapy ☐ Work hardening ☐ TENS unit

☐ Chiropractor visits ☐ Injections ☐ Surgery ☐ Counseling ☐ Hypnosis

☐ Biofeedback ☐ Acupuncture

List any tests you have had related to your current pain:

☐ X-ray ☐ CT scan ☐ MRI ☐ Myelogram ☐ Bone scan ☐ EMG ☐ Blood tests

ALLERGIES AND MEDICATIONS

Allegries and intolerances: (Please list all allergies or intolerances)

_____

_____

Current pain medications: Please list all prescription and non-prescription medications <u>you are currently taking</u> for pain: (Please include dose and frequency)

_____

_____

Previous pain medications. Please list all prescription and non-prescription medications <u>you have taken in the past</u> for pain: (Please include dose, frequency, and the reason each medication was stopped)

_____

_____

Other medications. Please list all prescription and non-prescription medications you are currently taking for other medical conditions: (Please include dose and frequency)

_____

_____

Are you currently taking any blood thinning medications? ☐No/☐Yes: _____

PAST MEDICAL PROBLEMS

Have you ever had any of the following medical conditions? (Check all that apply)

☐ Diabetes ☐ Bleeding disorder ☐ Heart murmur ☐ Rheumatic fever ☐ HIV or AIDS

☐ Stroke ☐ Heart attack ☐ Heart problems ☐ Aneurysm ☐ Circulation problem

☐ High cholesterol ☐ Seizures ☐ Cancer ☐ Kidney problems ☐ High blood pressure

☐ Respiratory problems ☐ Thyroid problems ☐ Ulcers ☐ Liver problems ☐ Heartburn

☐ Pacemaker ☐ Hepatitis ☐ Asthma ☐ Sleep apnea ☐ Defibrillator ☐ Fibromyalgia

☐ Other: _____

_____

PAST SURGERY

Please list any previous surgery you have had: (Please include the month and year each surgery was done)

_____

_____

_____

_____

_____

_____

FAMILY HISTORY

Does anyone in your family suffer from chronic illness: ☐No/☐Yes:

Relationship (e.g. father, sister, etc.) Illness

_____

_____

SOCIAL HISTORY

What was the highest level of education you completed?
☐ High school ☐ College ☐ Graduate school

What is you marital status?
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

How many children do you have? _____

Do you smoke? ☐No/☐Yes:
If yes, how many packs/day _____ *How many years have been smoking?*_____

Do you drink alcohol? ☐No/☐Yes:
If yes, how much and often do you drink? (e.g. 2 glasses of wine/day) _____

Do you use recreational drugs? ☐No/☐Yes: *If yes, please describe* _____

Do you exercise regularly? ☐No/☐Yes: *If yes, how often?* _____

WORK HISTORY

Are you currently working? ☐No/☐Yes: *If yes, who is your current employer:* _____

_____

What is your occupation? _____

Are you on disabled? ☐No/☐Yes: *If yes, how long have you been disabled?* __ _____

*What caused you to become disabled?*_____

PSYCHOSOCIAL HISTORY

Have you ever been treated for emotional/behavioral disorder? □No/□Yes: *If yes, please describe:* _____

Have you ever been treated for depression? □No/□Yes: *If yes, when:*_____

Have you ever attempted suicide? □No/□Yes: *If yes, when:*_____

Do you currently have suicidal thoughts? □No/□Yes

REVIEW OF SYSTEMS

Please circle any of the following problems that you are now experiencing:

Constitutional: weight change ◦ weakness ◦ fatigue ◦ fever

Eyes: change in your eyeglass prescription ◦ eye pain ◦ tearing ◦ double vision

Ear, Nose, Throat: hearing loss ◦ nasal congestion ◦ ringing in your ears ◦ dizziness ◦ sore throat

Cardiovascular: shortness of breath ◦ chest pain ◦ palpitations ◦ ankle swelling

Respiratory: cough ◦ sputum ◦ coughing up of blood ◦ difficulty breathing ◦ wheezing

Gastrointestinal: heartburn ◦ nausea or vomiting ◦ abdominal pain ◦ constipation ◦ diarrhea ◦ bowel incontinence ◦ bloody stool

Genitourinary: pain with urination ◦ bladder incontinence ◦ urgency ◦ blood in urine

Musculoskeletal: joint pain ◦ stiffness ◦ neck or backache

Skin: rash ◦ lumps ◦ itching ◦ hair changes ◦ nail changes

Neurological: headache ◦ weakness ◦ numbness ◦ seizures ◦ blackouts ◦ memory loss

Psychological: nervousness ◦ tension ◦ depression ◦ anxiety

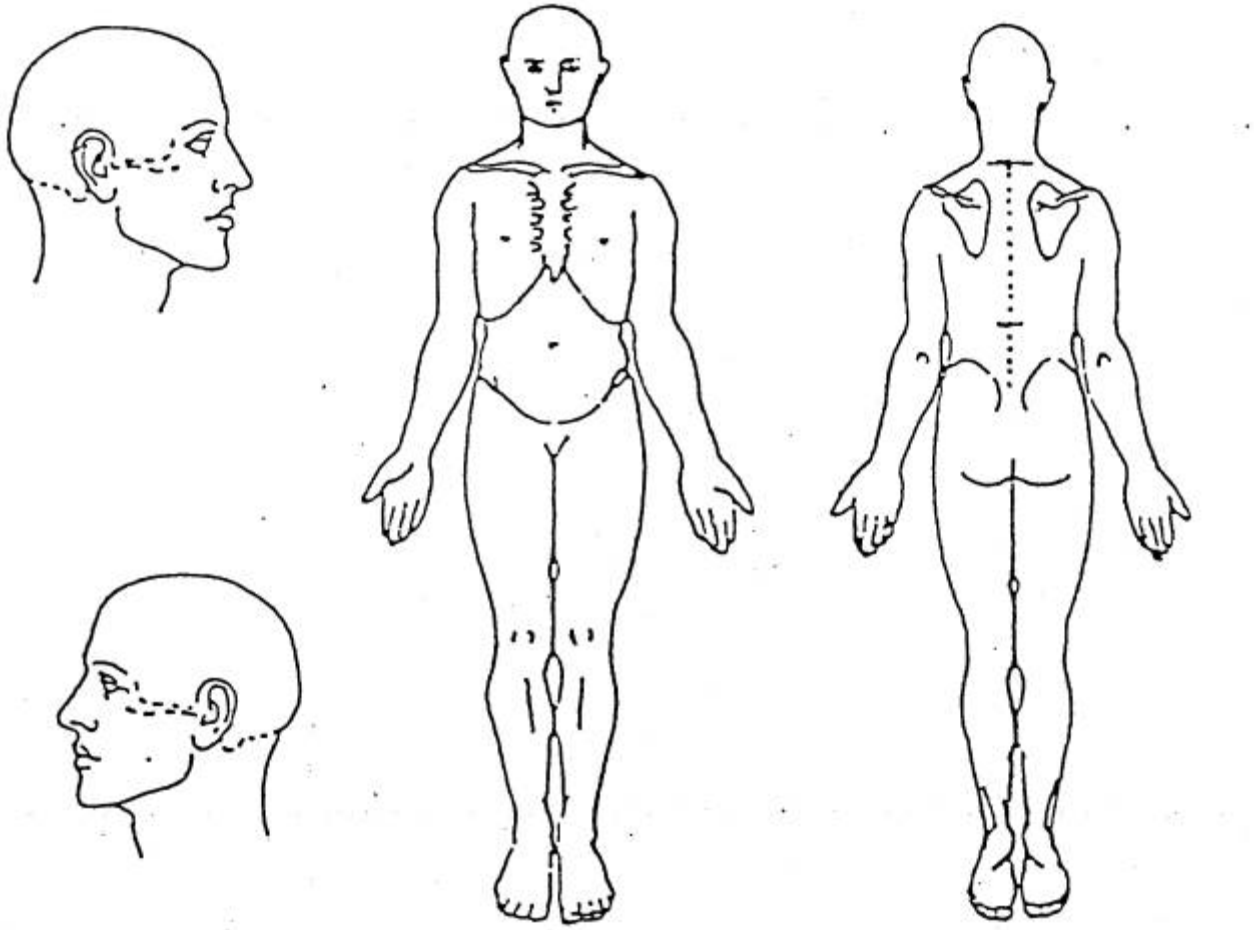
Endocrine: heat or cold intolerance ◦ sweating ◦ thirst ◦ hunger ◦ change in urination

Hematologic: bruising ◦ bleeding

Is there any chance you could be pregnant? □No/□Yes

WHERE IS YOUR PAIN?

Please shade the areas of your pain in the diagrams below.



I, the undersigned, have completed this form to the best of knowledge. The information that I have provided is true and accurate to the best of my knowledge.

_____ _____

Patient/Guardian Signature Date

_____ _____

Physician Signature Date