

PATIENT HISTORY

Lansdale Pain Management Center
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Patient Name _____ Date _____
Date of Birth _____ Sex _____ Marital Status _____
Telephone Numbers/Home () _____ Work () _____
Home Address _____
Street _____ email _____
City _____ State _____ ZIP _____

Family Doctor: _____ Family Doctor Phone Number: _____

General Health Review

Medical History (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illnesses, etc.)

Surgical History (**unrelated** to pain; such as appendectomy)

Surgical History (**related** to pain; such as laminectomy)

Allergies (include medication and food allergies)

Intolerances (include side effects from previous medications, such as gastritis, nausea, constipation, etc.)

Current Medications (include vitamins and birth control pills, if applicable)

Do you have any of the following? (Circle all that apply)

Headaches

Vision Problems
Hearing Problems
Dizziness
Difficulty Swallowing
Difficulty walking

Stomach Pain

Nausea
Vomiting
Constipation
Diarrhea
Incontinence

Chest Pain

Shortness of Breath
Urinary Problems
Rashes
Swollen Joints
Chronic Fatigue

Domestic Situation

With whom do you live? _____

Are there any substance abuse issues in the household? Yes _____ No _____

If yes, please explain _____

Are you able to take care of yourself? Yes _____ No _____

If not, please enter name of caregiver _____

Work History

Job

Years worked

Why did you leave?

Legal Matters

Are you presently involved in a lawsuit? Yes _____ No _____ If yes, please explain.

Substance Use

Which of the following drugs or substances, if any, have you used in the past? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you used it occasionally ("O"), frequently ("F"), or continuously ("C").

Alcohol _____
Heroin _____
Other _____
(specify)

Barbiturates _____
Amphetamines _____
Other _____
(specify)

Cocaine _____
Marijuana _____
Other _____
(specify)

Are you presently using any of the drugs or substances below? (Circle all that apply)

Next to each drug or substance that you've circled, indicate if you use it occasionally ("O"), frequently ("F"), or continuously ("C").

Alcohol _____
Heroin _____
Other _____
(specify)

Barbiturates _____
Amphetamines _____
Other _____
(specify)

Cocaine _____
Marijuana _____
Other _____
(specify)

Do you presently smoke cigarettes or use tobacco in any form? Yes _____ No _____

If not, did you ever smoke cigarettes or use tobacco in any form? Yes _____ No _____

How many packs do (did) you smoke a day? _____ For how many years? _____

INITIAL PAIN ASSESSMENT

By answering the following questions, you will help your physician better understand and treat your pain.

When and how did your pain problem start? _____

As far as you know, what is the cause of your pain (ie, the diagnosis)? _____

What doctors have you seen? When did you see them? What did they do? (for example: Doctor did physical exam, ordered tests, prescribed medication)

Doctor's Name	Month/Year Seen	What Was Done
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What tests and studies have been done? (for example: MRI, CT-Scan, X-Rays)	Month/Year Done	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List the body sites where you experience pain and circle the words that best describe the pain at that site. Also, indicate the intensity of the pain and those things that make your pain better or worse. Use a separate sheet for each body site.

Body Site _____

Circle the words that describe your pain.

- | | | |
|--------------|------------|-------------|
| Aching | Sharp | Penetrating |
| Throbbing | Tender | Nagging |
| Shooting | Burning | Numb |
| Stabbing | Exhausting | Miserable |
| Gnawing | Tiring | Unbearable |
| Intermittent | Continuous | |

Circle the number that best describes your pain at its **worst during the last month**.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

Circle the number that best describes your pain at its **least during the last month**.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

Circle the number that best describes your pain **on average during the last month**.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

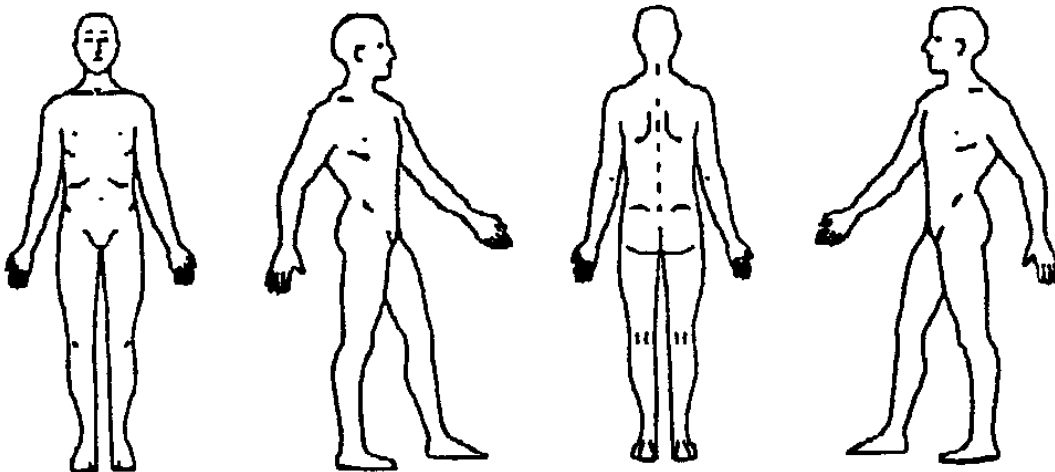
Circle the number that best describes your pain as it is **right now**.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

What sorts of things make this pain feel **better** (for example: heat, rest, medicine)?

What sorts of things make this pain feel **worse** (for example: walking, standing, lifting)?

On the diagram below, shade the area(s) where you feel pain. "X" the areas that hurt the most.



What pain treatments or medications are you receiving now or have received in the past? (For example, pain medications, physical therapy, acupuncture, TENS, etc.) Circle the number next to the treatment to signify the amount of pain relief that treatment is providing or has provided.

Treatment or Medication	No Relief	Complete Relief	Check If Receiving Now
	0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/>
	0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/>
	0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/>
	0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/>
	0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/>
	0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/>
	0 1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/>

Circle the numbers below that best describe how pain has interfered with your daily functioning.

General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not interfere					Completely interferes					

Mood

0	1	2	3	4	5	6	7	8	9	10
Does not interfere					Completely interferes					

Walking Ability

0	1	2	3	4	5	6	7	8	9	10
Does not interfere					Completely interferes					

Normal Work Routine

0	1	2	3	4	5	6	7	8	9	10
Does not interfere					Completely interferes					

Relations With Other People

0	1	2	3	4	5	6	7	8	9	10
Does not interfere					Completely interferes					

Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not interfere					Completely interferes					

Enjoyment of Life

0	1	2	3	4	5	6	7	8	9	10
Does not interfere					Completely interferes					

Ability to Concentrate

0	1	2	3	4	5	6	7	8	9	10
Does not interfere					Completely interferes					

Appetite

0	1	2	3	4	5	6	7	8	9	10
Does not interfere					Completely interferes					

What level of pain do you think you could function with on a daily basis?

0	1	2	3	4	5	6	7	8	9	10
<input type="text"/>										

No Pain

Worst pain imaginable

DIRECTIONS TO LANSDALE PAIN MANAGEMENT

FROM LANSDALE:

Take Broad Street to Route 309. Make a left and head NORTH on 309. First traffic light is WALNUT STREET. Go through that light. Get into the left lane. You will see the "In Flight Restaurant" on your right. Second light is ADVANCE LANE. Get into left turn lane and turn LEFT. It will look like you are going into the Car Wash America (formerly the Hatfield Car Wash). Stay on the little lane and go AROUND the car wash. Our building sits just behind the car wash. We are at the back of the building, first floor, and suite 103.

FROM POINTS SOUTH:

Get onto Route 309 and head NORTH. Go past the Montgomeryville Mall on the left. Cross Broad Street. The first traffic light after Broad Street is WALNUT STREET. Go through that light. Get into the left lane. You will see the "In Flight Restaurant" on your right. Second light is ADVANCE LANE. Get into left turn lane and turn LEFT. It will look like you are going into the Car Wash America (formerly the Hatfield Car Wash). Stay on the little lane and go AROUND the car wash. Our building sits just behind the car wash. We are at the back of the building, first floor, and suite 103.

FROM POINTS NORTH (QUAKERTOWN, SELLERSVILLE)

Get onto Route 309 and head SOUTH. Pass Walmart shopping center on the left. Go through two traffic lights. When you see the U-Haul self-storage facility you are approaching the light at ADVANCE LANE (This is the third light **after** the Walmart shopping center). Turn right at that light. It will look like you are going into the Car Wash America (formerly the Hatfield Car Wash). Stay on the little lane and go AROUND the car wash. Our building sits just behind the car wash. We are at the back of the building, first floor, and suite 103.

BLOOD THINNER/MEDICATION LIST – RULES

Patients:

The following is a list of medications that must be discontinued prior to your appointment because of risk of bleeding. **The list is not exhaustive, so if you are taking a medication not on the list that you suspect might contain aspirin or is a blood thinner, please call our office to verify.**

Must be off for 7 days prior to appointment and can restart after procedure:

Plavix, Pletal, Ticlid, Aggrenox, Trental.

Must be off for 5 days prior to appointment and can restart after procedure:

Warfarin, Coumadin

Must be off for 1-2 days prior to appointment and can restart after procedure:

Advil, Aleve, Anaprox, Aspirin 325 mg, Bufferin, Cataflam, Daypro, Ecotrin 325 mg, Excederine, Ibuprophen, Diclofenac, Indocin, Mobic, Motrin, Naprosyn, Naproxin, Orudis, Oxaprozin, Relafen, Toradol, Voltaren

Must be off for 24 hours prior to appointment and may be restarted 2 days after procedure:

Subcutaneous Injections like:

Heparin or Lovenox

With increasing frequency patients have been missing their scheduled appointments. Time is allotted for each patient and a missed appointment is time taken away from another patient who truly is in need of medical attention.

In an attempt to remedy this situation, the following policy is being instituted: To cancel an appointment, you need to give us 24 hours notice. If you do not show up for your scheduled appointment, or do not let us know at least 24 hours in advance, there will be a \$25 charge. We will not reschedule your appointment until this charge is paid.

*****COPAYS ARE DUE AT THE TIME OF SERVICE.**