

MEDICAL QUESTIONNAIRE

Pain Management & Regenerative Medicine

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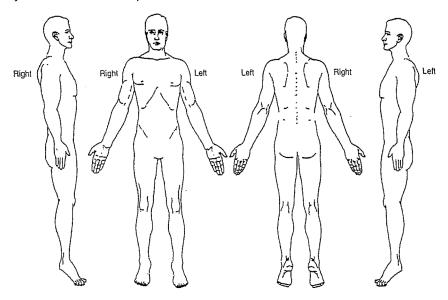
GENERAL					
Patient Name	Last Name	First Name	М.І.		Today's Date (MM/DD/YY)
Gender	Male	Female		Height	Weight

Which doctor referred you to OSS Pain Management & Regenerative Medicine?

PAIN: What is the current level of your pain?

Mark the drawing below with an X to show where you have the most severe pain.

Shade in the areas where you have less severe pain.



On a scale of 0) - 10 (0=r	no pain, 10	=worst	pain possible), wł	nat is your	level of	pain?	0	1	2	3	4	5	6	7	8	9	10
How often do y	ou have p	pain?																
Constantly	C	Comes & Goe	es	Certain Time of Da	ıy:		With	this A	Activit	ty:								_
Have you been	seen at	a Pain Mar	nageme	nt Clinic before?	No	Yes												
If yes, what	was the the	e date(s), du	ration, an	nd location / name of	clinic?													
How did your p	ain start?	•																
Work Injury	/ Illness	No Obviou	ıs Cause	Injury, Not at Work	Motor Ve	ehicle or I	Motorcyl	e Acc	ident	t C	Other:	: _						_
How long have	you had	this pain?																
How would you	ı describe	how your	pain fee	els?														_
What makes yo	our pain fe	eel:																
Better?																		_
Worse? _																		_
How is your sle	eep? Des	scribe.																_



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Patient Name Last Name

First Name

M.I.

Today's Date (MM/DD/YY)

HISTORY OF TREATMENT: How have you tried to manage the pain?

Have you used any of these treatment(s) to ease your pain? Please check as it applies, provide the date(s), and describe outcome.

			Date(s) Tried	Outcome / Reason(s) Stopped?
Services				
Physical Therapy	No	Yes		
TENS Unit	No	Yes		
Aqua Therapy	No	Yes		
Acupuncture	No	Yes		
Biofeedback	No	Yes		
Spinal Cord Stimulation (SCS)	No	Yes		
Relaxation, imagery, mindfulness	No	Yes		
Injections				
Epidural Injection	No	Yes		
Transforaminal (Nerve Block) Injection	No	Yes		
Sacroiliac (SI) Joint Injection	No	Yes		
Facet Injection	No	Yes		
Trigger Point Injection	No	Yes		
Rhizotomy Injection	No	Yes		
Other	No	Yes		
Regenerative Medicine				
Platelet Rich Plasma (PRP)	No	Yes		
Stem Cell	No	Yes		
Prolotherapy	No	Yes		
Cartilage Regeneration	No	Yes		
Nonsteroidal Medications				
Motrin (Ibuprofen)	No	Yes		
Aleve	No	Yes		
Naproxen	No	Yes		
Mobic (Meloxicam)	No	Yes		
Lodine (Etodolac)	No	Yes		
Other				
Aspirin	No	Yes		
Tylenol	No	Yes		
Other	No	Yes		
Muscle Relaxants				
Baclofen	No	Yes		
Robaxin	No	Yes		
Zanaflex	No	Yes		
Skelaxin	No	Yes		
Flexeril	No	Yes		



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Patient Signature: __

Patient Name Last Name First Name M.I. Today's Date (MM/DD/YY)

HISTORY OF TREATMENT: How have you tried to manage the pain?

Have you used any of these treatment(s) to ease your pain? Please check as it applies, provide the date(s), and describe outcome.

				Date(s) Trie	d Outcome /		(-, -	ropp	, ou .
Narcotics (Opiods)									
Codeine		No	Yes						
Percocet		No	Yes						
Oxycodone		No	Yes						
Hydrocodone (Norco)		No	Yes		·				
Opana (Oxymorphone)		No No	Yes						
Morphine		No	Yes		·				
Oxycontin Avinza		No No	Yes Yes						
Hysingla		No	Yes						
Duragesic (Fentanyl)		No	Yes						
Suboxone		No	Yes						
Neuromodulators		110	100						
Neurontin (Gabapentin)		No	Yes						
Topamax		No	Yes						
Lyrica		No	Yes						
Cymbalta		No	Yes						
Gabitril		No	Yes						
OCIAL HISTORY: Wha	t social fac	tors sho	ould we co		ur care?				
OCIAL HISTORY: Wha	t social fac	tors sho	ould we co		ur care? Amphetamines	Co	ocaine		Bath Salts
nat allergies do you have? OCIAL HISTORY: Whatave you ever used any of the Marijuana Heroin ease check your response.	t social fac e following dru Suboxone	tors shougs? Chec	ould we co	es. Inhalants	Amphetamines	Co	ocaine		Bath Salts
OCIAL HISTORY: Whatave you ever used any of the Marijuana Heroin ease check your response.	t social fac e following dru Suboxone Scale: 1 = Nev	tors shougs? Chec	ould we co	es. Inhalants	Amphetamines	Co 2	ocaine 3	4	
OCIAL HISTORY: What we you ever used any of the Marijuana Heroin ease check your response. How often do you have mo	e following dru Suboxone Scale: 1 = Nev od swings?	tors sho ugs? Chec Sedative er, 2 = Seldo	ck as it applied / Downers om, 3 = Somet	es. Inhalants imes, 4 = Often, 5	Amphetamines			4 4	Bath Salts 5 5
OCIAL HISTORY: What ave you ever used any of the Marijuana Heroin ease check your response. How often do you have mo How often do you smoke a	t social face of following drugs suboxone Scale: 1 = Nev od swings? cigarette with	tors sho ugs? Chec Sedative er, 2 = Selde in an hour	buld we cook as it applied / Downers om, 3 = Someter of waking u	es. Inhalants imes, 4 = Often, 5	Amphetamines 5 = Very Often 1	2	3	4	5 5
OCIAL HISTORY: What ave you ever used any of the Marijuana Heroin ease check your response. How often do you have more thow often do you smoke a How often have you taken the contract of the	e following dru Suboxone Scale: 1 = Nev od swings? cigarette with	tors shougs? Check Sedative er, 2 = Selde in an hour ther than the	ck as it applied / Downers om, 3 = Someter of waking under way it was	es. Inhalants imes, 4 = Often, 5	Amphetamines 5 = Very Often 1 1 1	2 2 2	3 3 3	4	5 5 5
OCIAL HISTORY: What ave you ever used any of the Marijuana Heroin ease check your response. How often do you have more How often do you smoke a How often have you taken the How often have you used it	e following dru Suboxone Scale: 1 = Nevod swings? cigarette with medication others.	tors sho ugs? Chec Sedative er, 2 = Seldo in an hour her than the	ck as it applied / Downers om, 3 = Sometic of waking under way it was five years?	es. Inhalants imes, 4 = Often, 5 ip? s prescribed?	Amphetamines 5 = Very Often 1 1 1	2 2 2 2	3 3 3	4 4 4	5 5 5
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Date: _