



CONTINENTAL
ANESTHESIA
Experts in Pain Management

**CONTINENTAL CHRONIC PAIN
Patient History**

Patient Name _____
Last First Middle Initial

Street Address _____ City _____ State _____ Zip Code _____

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Date of Birth ___/___/___ Age _____ Patient Sex (circle one): M F Marital Status (circle one): M S D W

Name of Employer _____ Occupation _____

Employment Address _____ City _____ State _____ Zip Code _____

Did you have any injury? Y N Explain _____

If yes, what was the date of injury? ___/___/___

Is the injury work related? Y N Is this injury the result of a motor vehicle accident? Y N

Is an attorney involved? Y N If yes, what is Attorney's name _____ Phone() _____

Did you have any previous injuries? _____

Who is referring you to our practice? _____ Phone() _____

Who is your Primary Care Physician? _____ Phone() _____

Have you seen any pain physicians for this problem in the past? Y N Name: _____

What was the reason to change your pain physician? _____

Approximately when did your pain start? _____

Is your pain (circle one) constant or intermittent? Describe your pain _____

What increases your pain? _____

What decreases your pain? _____

How has this pain affected your daily living activities, work and life? _____

What are your expectations regarding your pain? _____

Do you experience any weakness? Y N If yes, where? _____

Do you experience any tingling? Y N If yes, where? _____

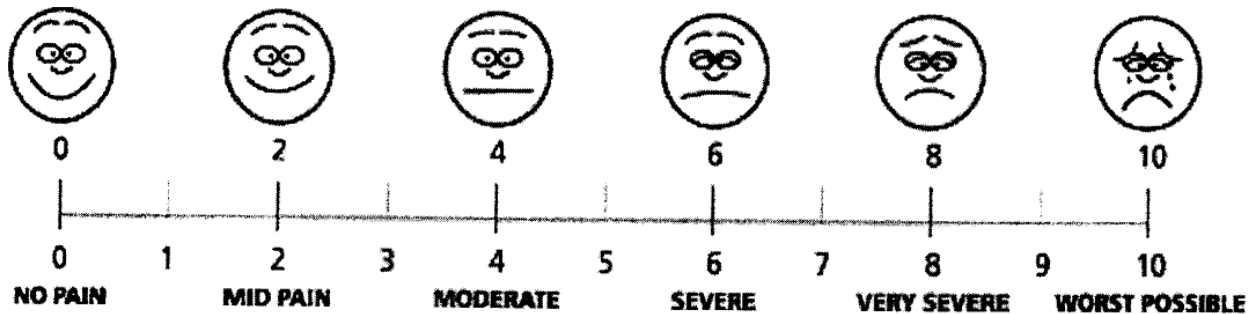
Do you experience any numbness? Y N If yes, where? _____

Has your pain gotten worse with time? Y N Do you have difficulty sleeping because of the pain? Y N

Do you have any bowel or bladder problems? Y N If yes please explain _____

As of today, what have you done to help relieve your pain? _____

Using the pain scale below, **rate your pain**



Do you have any of the following medical conditions? **Please mark yes or no for each.**

HEART	Yes	No
High or low blood pressure		
Coronary artery disease		
If yes, have you had the following:		
Angioplasty		
Cardiac Bypass		
Atrial fibrillation		
Aortic aneurysm		
Mitral valve prolapse		
Angina		
Congestive heart failure		
Peripheral vascular disease		
High cholesterol		

LUNGS	YES	NO
Asthma		
Do you or have you ever used smoked		
COPD		
Cancer		
Obstructive sleep apnea		

GASTROINTESTINAL / RENAL	YES	NO
Peptic Ulcers		
Hepatitis		
Liver disease		
Kidney disease		

NEUROLOGICAL	YES	NO
Migraine headaches		
Seizures (epilepsy)		
Depression		

ENDOCRINOLOGY	YES	NO
Diabetes		
Hyperthyroidism		
Hypothyroidism		

OTHER	YES	NO
Substance abuse		
Alcohol abuse		
Do you have any skin problems? Explain:		
Do you have any skeletal problems? Explain:		
Have you ever undergone psychiatric treatment?		
Do you have a history of excessive weight loss or weight gain?		
Do you or have you ever used tobacco?		
Do you or have you used alcohol?		
Do you or have you ever used street drugs / recreational drugs?		

Please list **allergies**: _____

Please list **all pain medications** you are currently taking: _____

Please list **all other medications** you are currently taking: _____

Please list **all surgeries** since childhood: _____

Have you ever had spine surgery? Y N If yes what is the name of the surgery? _____

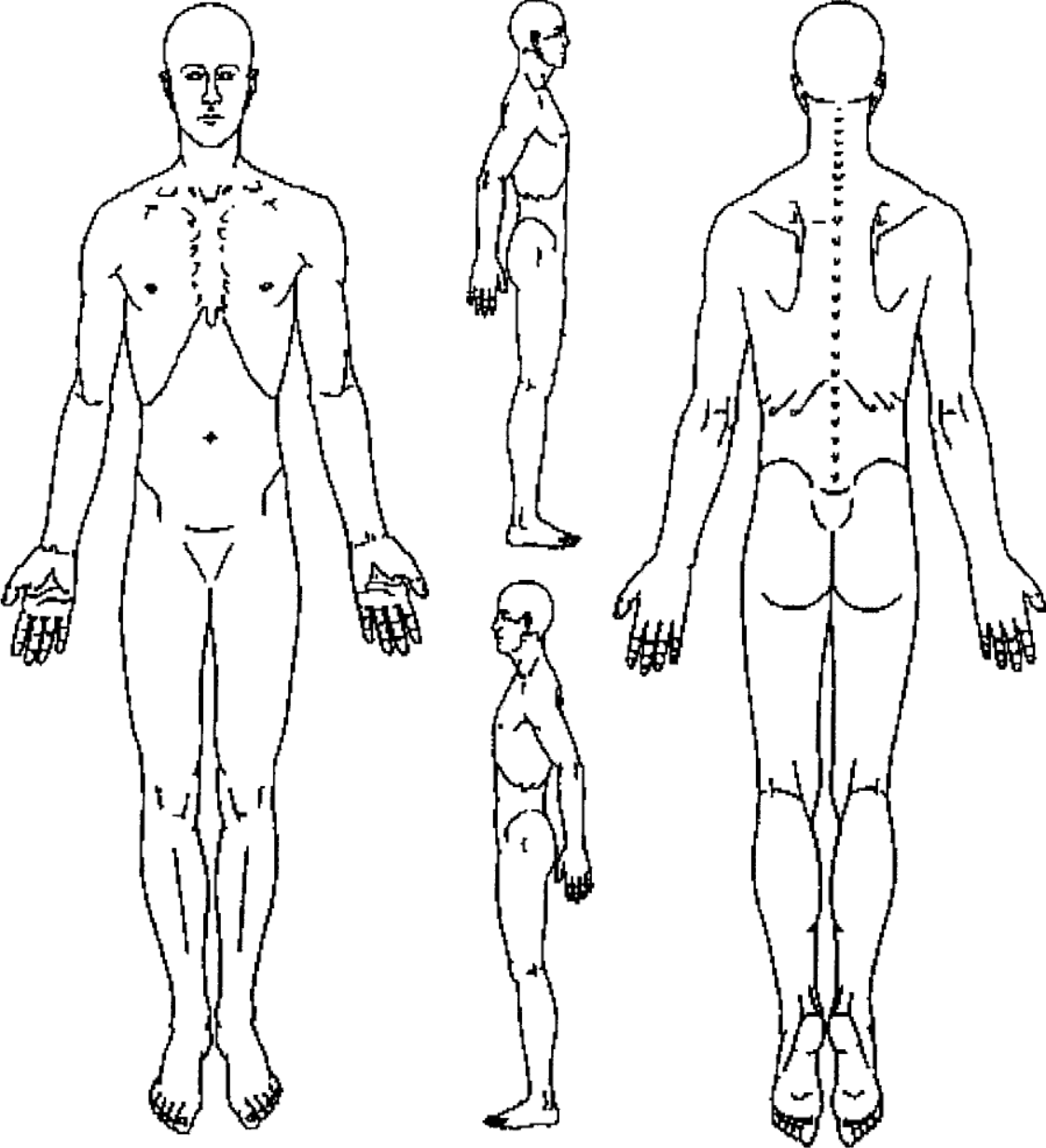
Have you ever had an epidural steroid injection? Y N If yes, did it help? Y N

What physician did the injection? _____

At what facility was the injection done? _____

On the diagram below, mark the areas on your body where you are experiencing pain or other symptoms right now. Use the following symbols:

Aching Numbness Pins and Needles Burning Stabbing
++++++ ===== oooooo xxxxxx /////



Signature of patient or legal representative

Relationship to patient

____/____/____
Date