Nocio
Interventional Pain Management

Tel: (480) 818-4314
Fax: (602) 865-8171

New Patient History

CC : What painful area needs to be addressed today? Example: “My low back hurts”

_____

HPI: When did the pain start for the very first time? (Onset): _____

Where do you hurt? (Location): _____

Describe the pain (Quality--Sharp/Dull, Ache, Squeeze/Tight, Searing)

_____

Severity (0-10 scale): 0 is no pain, 10 is the worst imaginable pain.
Your pain is _____ out of 10.

Duration: Circle ONE (1) of the Following Descriptions of Your Pain
Constant Pain
On and Off or “Intermittent” Pain

Context:
What Makes the Pain Worse or What Activity Brings On the Pain?

_____

What Gets Rid of the Pain or What Makes the Pain Better?

_____

Associated Signs and Symptoms:

Have you noticed bowel or bladder problems when you have the pain?
Circle YES or NO
Do you have other sensations or issues that seem to go with the pain?
Circle YES or NO
Does your leg or arm hurt, too (especially with low back or neck pain)?
Circle LEG or ARM or NONE

The information I provided above is accurate and complete to the best of my knowledge

(Signature) _____(Date) _____

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IMAGING RELATED TO YOUR CURRENT PAIN (MRI, X-RAY, CT, etc.):

What part of the body? _____

When? _____

Name of Imaging Facility? _____

PMH: List **all** your medical conditions (previous and current) and **surgeries** related to your pain.

Example: Diabetes, High Blood Pressure, Asthma, Spinal Fusion, Laminectomy

_____

_____

_____

_____

_____

_____

_____

Family History: Circle which blood relatives also have painful issues and/or had surgery to alleviate their pain?

Mother Father Brother Sister None of the above Not sure

SH : Circle all that apply

Tobacco (cigars, cigarettes, snuff, chew)
Alcohol: More than 2 servings per day (1 serving: 1 beer, 1 glass of wine, or 1 cocktail)
Alcohol: Less than 2 servings per day
Marijuana, THC or CBD (any form)
Prescribed Opioids/Narcotics (example: Percocet, Lortab, Oxycodone, Hydrocodone, Dilaudid)
Illicit drugs (example: Cocaine, Methamphetamine, Heroin, PCP, Opioids/Narcotics that are not prescribed)

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ROS : Circle if you have any of the following

1. Constitutional Complaints: Fevers, Chills, Fatigue, Unexplained Weight Loss, General weakness
2. Eyes: Blurry vision, Difficulty seeing, Glaucoma
3. Ears/Nose/Throat: Infection, Swelling, Pain
4. Cardiovascular Complaints: Leg swelling, heart problems, On Blood Thinners or Aspirin or Anti-inflammatories like Advil/Ibuprofen/Motrin, Aleve/Naproxen, Voltaren/Diclofenac, Stroke (ever), Mini-stroke/TIA (ever), Pacemaker, Rheumatic Heart Disease, Need for dental procedures
5. Gastrointestinal Complaints: Nausea, Vomiting, Diarrhea, Abdominal pain, Loss of control of bowels
6. Pulmonary Complaints: Shortness of breath, Cough, Blood in sputum, Asthma, Infection,
7. Genitourinary Complaints: UTI (kidney or bladder infection), kidney failure, dialysis, loss of control of bladder
8. Endocrine Complaints: Diabetes, Thyroid Condition, Cushing's Disease, Adson's Disease
9. Skin Complaints: Rash, Infection
10. Immune and Allergy Complaints: Infection recently, taking antibiotics, allergy to Latex, Steroid, Shellfish, Contrast Dye, certain Medications
11. Hematologic Complaints: On blood thinners, taking aspirin, bleeding disorder
12. Musculoskeletal: Weakness in arms or legs, limping/difficulty walking/standing
13. Psychiatric Complaints: Hallucinations, Severe Depression, Hopeless, Suicidal Thoughts
14. Neurologic Complaints: Numbness, Tingling, Sciatica, Neuropathy, Stroke(ever), Mini-stroke/TIA (ever), Brain Damage,
15. NONE OF THE ABOVE apply to me.

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MEDICATION ALLERGIES (List ALL regardless of severity, number of exposures)

Latex? YES or NO_____

Contrast Dye, Iodine, or Shellfish? YES or NO

_____

_____

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MEDICATIONS, VITAMINS, AND SUPPLEMENTS LIST

MED/VIT/SUPP	LAST DOSE		MED/VIT/SUPP	LAST DOSE

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