Carolinas Medical Center Northeast

Initial Pain Evaluation Database

Date:_____ Time:_____ Primary Care Provider:_____ Referring Physician:_____
Age:_____ Ht:_____ Wt:_____ T:_____ P:_____ R:_____ BP:_____ SpO2:_____
Medication allergies:_____
_____
Other allergies: □ Latex □ Tape □ Steroids □ Dyes □ Food □ Other_____
□ No known allergies

Current Medications: Include all over-the counter, vitamin, and alternative products

Medications	Dose	Route	Frequency	Time/date last taken

Past Medical History/Review of Systems

Cardiac

Born with heart problems	□No □Yes
High blood pressure	□No □Yes
Abnormal Heart rhythm	□No □Yes
Previous heart surgery	□No □Yes
Angina, chest pains	□No □Yes
Heart attack	□No □Yes
Congestive heart failure	□No □Yes
Heart cath, stress test or echo	□No □Yes

Respiratory

Colds, cough, bronchitis now	□No □Yes
Asthma	□No □Yes
COPD/Emphysema	□No □Yes
Shortness of breath	□No □Yes
Collapsed lung	□No □Yes
Sleep apnea	□No □Yes

Neurophysiological

Born with a nervous problem	□No □Yes
Brain, spinal cord or nerve problem	□No □Yes
Stroke or paralysis	□No □Yes
Epilepsy or seizures	□No □Yes

Integumentary

Eczema	□No □Yes
Rash	□No □Yes
Skin lesions	□No □Yes
Easy bruising/bleeding	□No □Yes
Zoster/shingles	□No □Yes

Liver/Gastrointestinal

Hiatal hernia/reflux	□No □Yes
Stomach/intestinal ulcers	□No □Yes
Jaundice/liver problems	□No □Yes
Constipation	□No □Yes
Nausea/vomiting	□No □Yes
Bloody/tarry stools	□No □Yes
Incontinence	□No □Yes

Renal/Urinary

Born with kidney problems	□No □Yes
Kidney stones	□No □Yes
Kidney/bladder problems	□No □Yes
Kidney failure	□No □Yes
Prostate problems	□No □Yes
Incontinence	□No □Yes

Musculoskeletal

Severe arthritis	□No □Yes
Broken bones now	□No □Yes
Fibromyalgia	□No □Yes
Polymyalgia	□No □Yes
TMJ dysfunction	□No □Yes

Endocrine/Reproductive

Diabetes	□No □Yes
Thyroid problems	□No □Yes
Received cortisone, prednisone or steroids within last 6 months	□No □Yes
Could you be pregnant	□No □Yes

Date of last menstrual cycle_____

Carolinas Medical Center Northeast

Hematologic/Oncologic

Bleeding problems	□No □Yes
Blood clotting problems	□No □Yes
Sickle cell trait/disease	□No □Yes
Anemia	□No □Yes
Cancer	□No □Yes
Type:_____ Year:_____	
Metastasis? _____	
Received chemotherapy	□No □Yes
Received radiation therapy	□No □Yes

HEENT

Visual disturbance	□No □Yes
Hearing loss	□No □Yes
Sinusitis	□No □Yes
Headache	□No □Yes
Dizziness	□No □Yes
Trouble swallowing	□No □Yes

Constitutional

Weight loss/gain	□No □Yes
Fever	□No □Yes
Chills	□No □Yes
Fatigue	□No □Yes
Drowsiness	□No □Yes

Psychiatric

Ever under care of psychologist/psychiatrist	□No □Yes
Depression	□No □Yes
Emotional problems	□No □Yes
Suicide attempt	□No □Yes
Panic attacks	□No □Yes
Contemplated suicide	□No □Yes

Surgical History

Have you or a family member experienced high fever associated with anesthesia? □No □Yes
Have you or a family member experienced paralysis associated with anesthesia? □No □Yes
List your past surgeries below:

Surgery	Date	Surgery	Date

Social/Family History

List occupation _____ Highest level of education_____
Describe your normal activities at work _____
List hobbies_____
Are you currently on disability? □No □Yes
Are you currently on medical leave? □No □Yes
Is there legal action pending in relation to your pain problem? □No □Yes
Are you on workman's compensation? □No □Yes
Marital status: □married □divorced □widowed □separated □single Number of children: _____
Who do you live with? □spouse □spouse/children □children □ alone □other_____
Has your pain caused you any sexual or marital problems? □No □Yes Explain:_____
Do you have family members or members of the household who suffer from chronic pain or have been seen in a pain clinic?
□No □Yes Explain:_____
Do you have a family history of:

Heart disease	□No □Yes	High blood pressure	□No □Yes	Diabetes	□No □Yes
Stroke	□No □Yes	Chronic pain	□No □Yes	Cancer	□No □Yes
Depression	□No □Yes	Drug dependency	□No □Yes	Alcoholism	□No □Yes
Suicide	□No □Yes	Other psychiatric condition	□No □Yes		

Health Habits

Do you currently use tobacco? □No □Yes Type:_____ Amount per day:_____ Number of years:____
Have you ever used tobacco? □No □Yes Type:_____ Amount per day:_____ Number of years:_____
What date did you quit using tobacco? _____
Have you ever used marijuana, cocaine or other street drugs? □No □Yes Type:_____ When:_____
Do you use beer, wine, or alcohol? □No □Yes On average, how much:_____ How often:_____

Carolinas Medical Center Northeast

Pain History

Describe the location of your pain:_____
When did your pain begin?_____
Do you know of any event that caused the onset of your pain? □No □Yes Explain:_____
_____
How often do you have pain ?_____ How long does your pain last?_____
Is your pain □ constant or □ intermittent?
Using the pain scale, rate the pain you are having right now _____
Are you ever pain free? □No □Yes Explain:_____
Does the pain radiate to another part of your body? □No □Yes Explain:_____
Do you have numbness, tingling, or burning in your arms or legs? □No □Yes Explain:_____
Do you have weakness in your arms or legs? □No □Yes Explain:_____
Have you had loss of bowel or bladder control with your pain? □No □Yes Explain:_____
Do you have any other symptoms associated with your pain? □No □Yes Explain:_____

What aggravates your pain?

Sitting □No □Yes
Standing □No □Yes
Walking □No □Yes
Running □No □Yes
Lying □No □Yes
Working □No □Yes
Lifting □No □Yes
Bending □No □Yes
Climbing stairs □No □Yes
Other_____

What relieves your pain?

Rest □No □Yes
Lying □No □Yes
Sitting □No □Yes
Heat □No □Yes
Cold □No □Yes
Medication □No □Yes
Other_____

What tests/studies have you undergone to evaluate your pain?

		Date	Where
X-rays	□No □Yes		
CT scan	□No □Yes		
MRI	□No □Yes		
Myelogram	□No □Yes		
Bone scan	□No □Yes		
EMG/NCV	□No □Yes		
Ultrasound	□No □Yes		
Discography	□No □Yes		
Other_____			

Have you ever received care from another pain clinic or specialist for your pain? □No □Yes
If yes, list information below:

Name	Where	Date

Have you ever been disengaged from a pain clinic? □No □Yes Explain:_____
Who was the last physician you saw and for what reason?_____
Were you prescribed any pain medications? □No □Yes Explain:_____
Have you ever signed a narcotic or medication agreement? □No □Yes

Which of the following therapies have you received in the past for your pain? **Where?** **Any benefit?**

Nerve block	□No □Yes	Type_____	How many?_____	_____	_____
Steroid injections	□No □Yes		How many?_____	_____	_____
Trigger point injections	□No □Yes			_____	_____
Physical therapy	□No □Yes	Type_____	How long?_____	_____	_____
Accupuncture	□No □Yes			_____	_____
TENS	□No □Yes			_____	_____
Chiropractic care	□No □Yes			_____	_____
Relaxation	□No □Yes			_____	_____
Biofeedback	□No □Yes			_____	_____
Hypnosis	□No □Yes			_____	_____
Pain psychologist	□No □Yes			_____	_____
Spinal cord stimulation	□No □Yes			_____	_____
Vertebroplasty	□No □Yes			_____	_____
Radiofrequency lesioning	□No □Yes			_____	_____
Other _____				_____	_____

Have you ever used any of the following pain medications?

		Any benefit?			Any benefit?
Oxycontin	□No □Yes	_____	Dilaudid	□No □Yes	_____
Oxycodone	□No □Yes	_____	Demerol	□No □Yes	_____
Tylox	□No □Yes	_____	Codeine	□No □Yes	_____
Percocet	□No □Yes	_____	Tylenol #3	□No □Yes	_____
Percodan	□No □Yes	_____	Lortab	□No □Yes	_____
MS Contin	□No □Yes	_____	Lorcet	□No □Yes	_____
Morphine	□No □Yes	_____	Darvocet	□No □Yes	_____
Methadone	□No □Yes	_____	Darvon	□No □Yes	_____
Duragesic patch	□No □Yes	_____	Wygesic	□No □Yes	_____
Actiq lozenge	□No □Yes	_____	Other _____		_____

Any side effects or reactions to these medications?_____

Have you used any of the following medications for your pain?

		Any benefit?			Any benefit?
Soma	□No □Yes	_____	Ultram	□No □Yes	_____
Flexeril	□No □Yes	_____	Baclofen	□No □Yes	_____
Zanaflex	□No □Yes	_____	Neurontin	□No □Yes	_____
Elavil	□No □Yes	_____	Tegretol	□No □Yes	_____
Pamelor	□No □Yes	_____	Mexilitine	□No □Yes	_____
Trazadone	□No □Yes	_____	Clonidine	□No □Yes	_____
Valium	□No □Yes	_____	Zostrix	□No □Yes	_____
Ativan	□No □Yes	_____	Zonogran	□No □Yes	_____
Ambien	□No □Yes	_____	Aspirin	□No □Yes	_____
Klonopin	□No □Yes	_____	Tylenol	□No □Yes	_____
Ibuprofen	□No □Yes	_____	Celebrex	□No □Yes	_____
Naprosyn	□No □Yes	_____	Vioxx	□No □Yes	_____
Medrol/steroids	□No □Yes	_____	Bextra	□No □Yes	_____
Other_____		_____			

Any side effects or reactions to these medications?_____

Nurse signature_____ Patient signature_____