

Patient Health Questionnaire

Pain Specialists of Texas, 4927 Lake Ridge Parkway, Suite 170, Grand Prairie, TX 75052.
Phone: 972-606-8980 Fax: 972-606-8923.

List other doctors including pain physicians/pain clinics who have treated you for this pain problem:

Have you had previously injections/blocks/epidurals for your pain? No Yes, provide details:

List tests that have been performed (i.e. CT/CAT scan, MRI, EMG, discogram, myelogram, etc)

Circle any treatment you have tried before:

Physical Therapy Chiropractor Massage Therapy Ice Heat TENS unit Other:

Please answer the following questions if your problem is the result of an injury:

- I never had back/neck problems before this injury.
- I had back/neck problems before and this injury made the problem worse.
- This injury occurred at work.
- This injury did not occur at work.
- I have filed a claim through workers compensation.
- I have pursued or will pursue legal action as result of this injury.

Date of injury: ___/___/___

Medication history

Are you allergic to any medication?

No Yes _____

List all pain medications you had **in the past** and how they worked for you (side effects).

Medication Name	Maximum dosage taken	Effect/Side effect

List all your current medication, dosages and how often you take them.

Medication Name Current/maximum dosage taken Effect/Side effect

Are you taking any blood thinners (aspirin-containing medication, clopidrogel (Plavix®), ticlipidine (Ticlid®), coumadin (Marcumar® and other brand names), ginkgo products, ginseng, garlic products? No Yes _____

Past medical history

Do you had or have any of the following conditions?

Any contagious diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suppressed immune system	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart disease or chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung disease/asthma/COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach ulcers/gastritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizure disorder, Stoke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver disease/hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered any of the above questions with yes, please explain:

Previous operations (for your pain problem and for other conditions) and dates:

Family history (blood relatives)

Cancer Yes No Chronic pain Yes No Fibromyalgia Yes No
Rheumatoid arthritis/Lupus/scleroderma Yes No Blood disorders Yes No
Other Yes No _____

Social History

Marital status single married divorced legally separated widowed
Occupation: _____ Currently: Full-time part-time retired disabled

I have missed significant time from work because of my pain Yes No
 Because of my pain I am working part-time or limited duty Yes No
 Have you ever been hospitalized for your pain problem? Yes No If yes, how often ____.
 The last date I worked was ___/___/____. I have been on disability since ___/___/____.
 Please indicate last grade completed in school _____.
 Tobacco: Do you smoke? Yes No If no, when did you quit? ___/___/____.
 If yes, for how many years? _____ How many packs per day? _____
 Alcohol: Do you drink alcohol? Yes No If yes, how often? _____
 Did you ever drink heavy in the past? Yes No
 Illicit drugs: Are you currently using any illicit drugs (marijuana, cocaine, amphetamines, heroin and others)? Yes No If yes, what? _____
 Last time used: _____

Review of systems

Fever/chills	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty controlling bowels	<input type="checkbox"/> Yes <input type="checkbox"/> No
Night sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty controlling urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any new rashes or blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Red swollen joints	<input type="checkbox"/> Yes <input type="checkbox"/> No
Persistent cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea/Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sudden weight gain/loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recurrent infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clotting problems/DVT	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visual disturbances	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No

Psychological History

Do you feel sad? Always Frequently Occasionally Rarely Never
 Do you feel helpless? Always Frequently Occasionally Rarely Never
 Do you feel hopeless? Always Frequently Occasionally Rarely Never
 Do you feel tense and worry all the time? Yes No
 Do you ever act in an angry or aggressive way (breaking objects, hitting people)? Yes No
 Do you have any history of mental health treatment? Yes No
 Have you ever been hospitalized for psychiatric reasons? Yes No
 Do you have panic attacks? Yes No Are you claustrophobic? Yes No
 Have you ever had any thoughts of wanting to die? Yes No
 Do you presently have any thoughts of harming or hurting anyone or yourself? Yes No

Miscellaneous

Is there anything else that we have not asked and that you would like to tell us?
