Patient Health Questionnaire

Pain Specialists of Texas, 1759 Broad Park Circle South, Suite 101, Mansfield, TX 76063
Phone: 682-518-0682 Fax: 682-518-1334

List other doctors including pain physicians/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 Yoga Acupuncture
Other:

Please answer the following statements 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 a result of this injury.
Date of injury: _____/_____/_____

Medication history

Are you allergic to any medication?
□ **No** □ **Yes** _____

List **all** your current medication (including pain medications), 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®), Eprasugrel (Effient®), dabigatran (Pradaxa®), coumadin (Marcumar® and other brand names), rivaroxaban (Xarelto®), aggranox, heparin, gingko biloba, ginseng, garlic products?
□ **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

Past medical history

Do you have any of these conditions currently or had them in the past?

Any contagious diseases	□ Yes □ No	Thyroid disease	□ Yes □ No
High blood pressure	□ Yes □ No	Bleeding problems	□ Yes □ No
Diabetes	□ Yes □ No	Suppressed immune system	□ Yes □ No
Heart disease or chest pain	□ Yes □ No	Cancer	□ Yes □ No
Lung disease/asthma/COPD	□ Yes □ No	Stomach ulcers/gastritis	□ Yes □ No
Kidney disease	□ Yes □ No	Seizure disorder, stroke	□ Yes □ No
Liver disease/hepatitis	□ Yes □ No	Rheumatoid arthritis	□ Yes □ 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, never smoker or quit on ____/____/_____.
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	□ Yes □ No	Difficulty controlling bowels	□ Yes □ No
Night sweats	□ Yes □ No	Difficulty controlling urine	□ Yes □ No
Difficulty breathing	□ Yes □ No	Any new rashes or blisters	□ Yes □ No
Chest pain	□ Yes □ No	Red swollen joints	□ Yes □ No
Persistent cough	□ Yes □ No	Numbness	□ Yes □ No
Constipation	□ Yes □ No	Weakness	□ Yes □ No
Diarrhea	□ Yes □ No	Depression	□ Yes □ No
Nausea/Vomiting	□ Yes □ No	Anxiety	□ Yes □ No
Sudden weight gain/loss	□ Yes □ No	Recurrent infections	□ Yes □ No
Bleeding problems	□ Yes □ No	Clotting problems/DVT	□ Yes □ No
Visual disturbances	□ Yes □ No	Headaches	□ Yes □ No
Blood in urine	□ Yes □ No	Dizziness	□ Yes □ 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?