Apex Pain Specialists – Follow-Up Patient Medical History Intake Form

Name______________________ Age ____ Today's Date: ________/________/_________

Date of Birth: _____/______/__________ Referred By:____________________________

What problem/issue brings you here today?

Since your last physician visit, are your symptoms: Better Worse Unchanged

Have you undergone any treatment since last visit? Was it helpful?

Please make a mark on the line below to indicate the level of discomfort you have today

No Pain ____ Worst Pain Ever

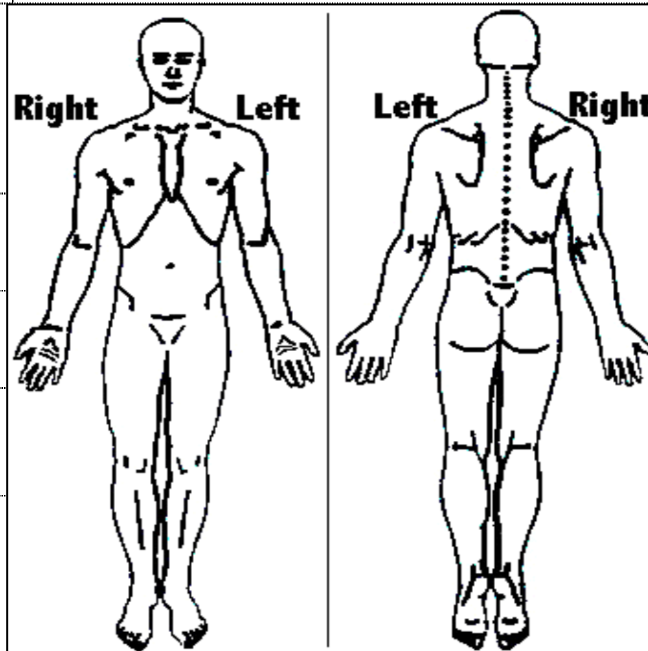
0 1 2 3 4 5 6 7 8 9 10

Please describe what the pain feels like:

Dull Sharp Achy Burning Cold Crampy Numbness

Shooting Stabbing Throbbing Tingling Tight

Please draw where you have pain or discomfort



Please describe the time course of your pain:

Constant Intermittent Worsening Improving Unchanging

What makes it better?

What makes it worse?

Do you have any associated symptoms?
None Tingling Numbness Arm/Leg Weakness Incontinence

What do you do for exercise?

Do you use a cane or walker?

List activities you are now unable to perform because of pain. Is your sleep affected by the pain?

Current Medications: *any new medications?*	Allergies: *Reaction?*

Any New Medical problems, surgeries, or allergies?

Family History: *Please circle all that apply*

Bipolar disorder	Heart disease	Cancer	Depression
Diabetes	High blood pressure	Substance abuse	Arthritis

Social History: **Marital Status:** *Any change in status since last visit?*

	Current	Quit (When)	Never
Tobacco use (cigarette, cigar, pipe, chew):			
Illicit drug use (cocaine, marijuana, heroin, ecstasy, PCP):			
Opioid use (hydro/oxycodone, morphine, oxycontin, fentanyl):			
History of substance abuse/addiction?			
Number of alcoholic beverages per week?			

Occupation:					
Employment Status:	Full-time	Part-time	Light Duty	Off Duty due to injury	Full-time Parent

Review of Symptoms: **Please indicate by circling if you are experiencing any of the following symptoms**

Fatigue | Fever | Loss of appetite | Unintentional weight loss

Change in vision | Loss of vision | Double vision | Difficulty swallowing

Chest pain | Irregular heartbeat | Leg swelling | Cold extremities

Shortness of breath | Wheezing | Cough

Nausea | Vomiting | Black/bloody stools | Loss of control of stools | Constipation | Heartburn

Loss of control of urine | Urinary frequency | Difficulty urinating | Pain/burning on urination

Possibly pregnant | Painful intercourse

Easy bleeding | Easy bruising | Taking blood thinners | Enlarged lymph nodes

New rash | Dry/sensitive skin

Arm/leg weakness | Numbness | Tingling | Dizziness | Loss of balance | Headache | Seizures

Back/neck pain | Joint pain | Joint swelling | Muscle cramps/pain

Anxiety | Serious depression | Sleep disturbance | Suicidal thoughts