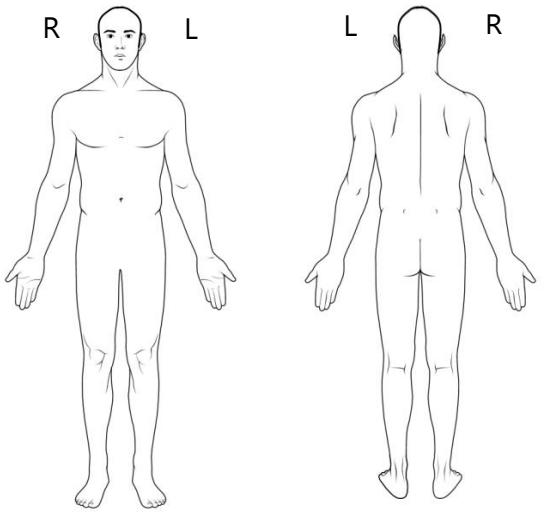
KATY
Pain and Spine

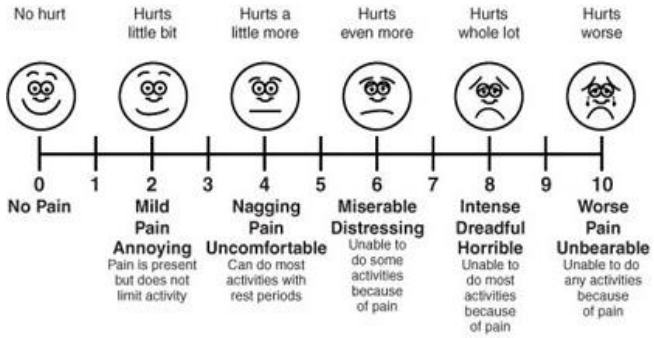
☐ **Karan Madan, M.D.** ☐ **Nimish Davé, MD**

Patient Name: _____ DOB: _____ Today's Date: _____
PCP: _____ Were you referred by another physician? _____

If not, how did you hear about us? _____



Mark on the diagram above where your pain is located.



Please use the diagram above to specify your areas of pain

What number on the scale **(0-10)…**
…best describes your pain **right now**? _____
…best describes your **worst pain**? _____
…best describes your **least pain?** _____

PAIN DESCRIPTION

Where is your WORST area of pain located? _____

Does your pain radiate? **YES / NO**: If so, where to? _____

Do you have any additional areas of pain? **YES / NO:** If so, where? _____

The Pain began? _____ **(DAYS / WEEKS/ MONTHS/ YEARS)**

How did it begin: **GRADUALLY / SUDDENLY**

Since your pain began, has it **(DECREASED / INCREASED / REMAINED THE SAME)**?

Is this from a prior injury? **(YES/NO)** What is the date of injury ___/___/_____ Motor vehicle accident / work related / sports / slip or fall

***Describe your pain…Circle all that apply*:**

Aching Cramping Hot/Burning Tiring/Exhausting Dull Shock-like Shooting Spasms Squeezing Throbbing Numbness
Swelling Stabbing/Sharp Clicking Locking Popping Pain at rest Pain at Night Pain with Activities Soreness
Tingling/Pins & Needles OTHER:_____

What word best describes your frequency of pain? **(CONSTANT / INTERMITTENT)**

When is your pain at its worse? **(MORNING / DAY / EVENINGS / MIDDLE OF NIGHT)**

Circle all of the following activities that are adversely/negatively affected by pain:

Enjoyment of Life Ability to work Normally Worsened sleep General Activity Recreational Activities Worsened mood Walking
Relationships with People Ability to walk normally

***The Pain is Improved By…*Circle all that apply:**

Acupuncture Biofeedback Chiropractic Massage Physical Therapy Psychological Therapy TENS Unit Joint Injections
Epidural Steroid Injections Podiatrist Treatment Ice Heat Rest Elevation Muscle Relaxers Assistive Device
Immobilization NSAIDS Steroid Injections Home Exercises Hypnosis Trigger Point Injections Medical Branch Blocks
Nerve Blocks Radiofrequency Ablation Spinal Cord Stimulator Spine Surgery Vertebroplasty/Kyphoplasty

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***Symptoms worsen when…Circle all that apply*:**

Weight bearing Standing Driving Squatting Kneeling Sitting Bending Climbing Twisting Lying Supine Moving Walking Engaging in activities Lifting OTHER:_____

PREVIOUS STUDIES

Circle all that apply:

X-RAYS CT SCAN MRI EMG/NCV BONE SCAN MYELOGRAM DISCOGRAM DEXA SCAN ULTRASOUND

Medications you have tried for your pain: ***Write on back of page for more***

MEDICATION NAME	WHO PRESCRIBED/OTC	DATES USED	Effective/Not Effective
			Effective/Not Effective
			Effective/Not Effective
			Effective/Not Effective
			Effective/Not Effective
			Effective/Not Effective

ANESTHESIA HISTORY

Have you ever had anesthesia (sedation for a surgical procedure)? **YES / NO**

If so, have you ever had any adverse reaction to anesthesia? **YES / NO**

Which type of anesthesia did you react adversely to? Please circle all that apply.

LOCAL ANESTHESIA EPIDURAL GENERAL ANESTHESIA IV SEDATION

PAST MEDICAL HISTORY

Please circle all that apply:

MUSCULOSKELETAL

Amputation Rheumatoid Arthritis
Carpal Tunnel Syndrome Bursitis
Fibromyalgia Tennis Elbow Lupus
Chronic Low Back Pain Osteoporosis
Chronic Joint Pain Phantom Limb Pain
Chronic Neck Pain Osteoarthritis
Vertebral Compression Fracture

RESPIRATORY

Bronchitis Pneumonia Asthma
Exposure to Mold Emphysema/COPD
Tuberculosis

GASTROINTESTIONAL

Bowel Incontinence Constipation
Acid reflux Gastrointestinal Bleeding

HEAD/EYES/NOSE/THROAT

Headaches Head Injury
Thyroid Disease Migraines
Glaucoma

GENERAL

Cancer
Diabetes
HIV/AIDS

LIVER

Hepatitis A
Hepatitis B
Hepatitis C

GENITOURINARY/NEPHROLOGY

Bladder Infection Dialysis
Kidney Infection Kidney Stone
Urinary Incontinence

CARDIOVASCULAR/HEMATOLOGIC

Anemia High Cholesterol Stroke
Bleeding Disorder High Blood Pressure
Mitral Valve Prolapse Heart Attack
Coronary Artery Disease Murmur
Phlebitis Pacemaker/Defibrillator
Poor Circulation

NEUROPSYCHOLOGICAL

Alcohol Abuse Alzheimer Disease
Epilepsy Multiple Sclerosis
Paralysis Peripheral Neuropathy
Schizophrenia Seizures Bipolar
Prescription Drug Abuse Depression

Over the past 2 weeks, how often have you been bothered by the following problems?

(0) Not at all (1) Several days (2) More than half the days (3) Nearly every day

1. Little interest or pleasure in doing things? _____
2. Feeling down, depressed or hopeless? _____

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ALLERGIES

Medication Name:	Reaction:	Allergy or Side Effect:
		Allergy or Side Effect
		Allergy or Side Effect
		Allergy or Side Effect
		Allergy or Side Effect

Write on back of page for more

PAST SURGICAL HISTORY

Surgery	Date	Performed by Who:

Write on back of page for more

FAMILY HISTORY

Circle all appropriate diagnosis as they pertain to your biological mother & father ONLY

☐ Please ***check*** if you have no significant family medical history. Were you adopted? **YES/ NO**

Mother / Father	Alcohol Problems	***Mother / Father***	Headache
Mother / Father	Gambling Problems	***Mother / Father***	Heart Disease
Mother / Father	Diabetes	***Mother / Father***	Liver Disease
Mother / Father	Drug Problems	***Mother / Father***	High Blood Pressure
Mother / Father	Kidney Disease	***Mother / Father***	Smoking
Mother / Father	Rheumatoid Arthritis	***Mother / Father***	Cancer
Mother / Father	Stroke		

SOCIAL HISTORY

Are you capable of becoming pregnant? **YES / NO**

If so, are you currently pregnant? **YES / NO**

What is your occupation? _____

Are you currently working? **YES / NO**

Circle all that apply below.

ALCOHOL USE	TOBACCO USE	ILLICIT DRUG USE
Current Alcoholism	Current tobacco user	Denies any illicit drug use
History of Alcoholism	Former tobacco user	Currently using illicit drugs
Social Alcohol Use	Never used tobacco	
Never Drinks Alcohol	Chewing Tobacco	
Daily limited Alcohol Use	E-Cigarette/Vape	

Please list all illicit drugs: _____

Have you formerly used illicit drugs? **YES / NO** If so, please list which. _____

Have you ever abused narcotic or prescription medications? **YES / NO**

Are you recovering from drugs, alcohol, or any addiction? **YES / NO**

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REVIEW OF SYSTEMS

Circle the following symptoms that you currently suffer from.
Note: Diagnosed conditions/diseases should be noted under past medical history section.

CONSTITUTIONAL
Weakness Weight gain
Fatigue Weight loss
Night Sweats

EYES
Recent vision changes
Eye glasses/contacts

EARS/NOSE/THROAT
Dental Problems Ringing in ears
Earaches Sinus Problems
Nosebleeds Recurrent sore throat

GASTROINTESTINAL
Acid Reflux Abdominal cramps
Constipation Diarrhea
Vomiting Dark & tarry stools
Coffee ground appearance in vomit

CARDIOVASCULAR
Chest Pain Blood clots
Murmur Irregular Heartbeat
Rapid Heartbeat Palpitations
Swollen Extremities Fainting

RESPIRATORY
Cough Wheezing
Shortness of breath on exertion/effort
Shortness of breath at rest

PSYCHIATRIC
Depressed mood Stress
Anxiety Suicidal thoughts

GENITOURINARY/NEPHROLOGY
Blood in urine Low frequency/volume
Painful urination Incontinence
Erectile dysfunction Decreased urine
Flank pain

INTEGUMENTARY/SKIN
Change in skin color Pruritus
Dry skin Rashes

MUSCULOSKELETAL
Joint swelling Joint pain
Back pain Muscle spasms
Neck pain Pelvic pain
Joint Stiffness

ENDOCRINE
Heat intolerant Cold intolerant
Hair changes Excessive thirst

NEUROLOGICAL
Dizziness Seizures
Headaches Memory loss
Numbness/tingling Difficulty with speech
Incoordination

HEMATOLOGIC/LYMPHATIC
Easy bruising Easy bleeding
Slow healing wounds
Lymphadenopathy

ALLERGIC/IMMUNOLOGIC
Recurrent infections
Hives
Swelling
Itching eye/nose

PATIENT CARE TEAM

DOCTOR	NAME	PHONE	FAX
PCP/Family Care			
Cardiologist			
Neurologist			
Orthopedic Surgeon			
Imaging Center			

Do you have a Medical Power of Attorney or DNR? YES/NO

Name: _____