

Pain History

Instructions

To do the best possible job with your pain, your doctor needs details about your history, including current and past medical problems, medications, health habits, and family history. For questions that ask about how you feel, please give your best answer yourself. The information about your past medical history may be gathered from both you and your family members.

Date:

My name is:

My telephone number is:

Pain History

Please give your best answer to the following questions:

1. Where is the pain? (e.g., example: knees, joints, back, head). Does it seem to move anywhere else?
2. How and when did the pain begin?
3. Tell us all you can about the pain:
What does it feel like (burning, tingling, shooting, sharp, aching), what time of day does it occur, what makes it start, what makes it better, and what makes it worse?
4. Please tell us all you know about previous evaluations of your pain. Particularly, tell us about any X-rays, MRIs, or other procedures done to find out the cause.
5. What have you been told is causing your pain?

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6. Have you had any surgeries or procedures for treatment of your pain? Don't forget therapies and injections. If so, tell us what, where, and by whom. Also tell us how well the treatments worked.

- 7.1. What medications have you taken for the pain and how well have they worked?

- 7.2. What medicines didn't work out for you and why (include *both* prescription and over-the-counter medicines, creams and herbals; start back when you first developed your pain problem)?

8. If you have any specific ideas of what should be done for your pain, please write them here.

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Persistent Pain Questionnaire

Please choose the best response to the following questions:

1. How much does your pain interfere with walking?

Not at all	A little	Moderately	A lot
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2. How much does your pain interfere with enjoying your life (socializing, travel, hobbies, and work)?

Not at all	A little	Moderately	A lot
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3. How much does your pain interfere with shopping?

Not at all	A little	Moderately	A lot
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4. How much does your pain interfere with driving?

Not at all	A little	Moderately	A lot
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5. How much does your pain interfere with your ability to exercise?

Not at all	A little	Moderately	A lot
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6. How much does your pain interfere with taking a bath?

Not at all	A little	Moderately	A lot
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7. How much does your pain interfere with getting to the toilet on time?

Not at all	A little	Moderately	A lot
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8. How much does your pain interfere with your ability to think clearly?

Not at all	A little	Moderately	A lot
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9. How much does your pain interfere with your sleep?

Not at all	A little	Moderately	A lot
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10. How much does your pain interfere with your appetite?

Not at all	A little	Moderately	A lot
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11. How much does your pain interfere with your mood and spirits?

Not at all	A little	Moderately	A lot
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12. How much does your pain interfere with your relationships with family and friends?

Not at all	A little	Moderately	A lot
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13. How much does your pain interfere with your energy?

Not at all	A little	Moderately	A lot
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Past Medical History

Have you been affected by any of the following problems or conditions? If so, when was it first found?

Condition	When?	Yes	No
Headache	_____	<input type="checkbox"/>	<input type="checkbox"/>
“TMJ” or jaw pain	_____	<input type="checkbox"/>	<input type="checkbox"/>
Dental pain	_____	<input type="checkbox"/>	<input type="checkbox"/>
Neck pain	_____	<input type="checkbox"/>	<input type="checkbox"/>
Problems swallowing	_____	<input type="checkbox"/>	<input type="checkbox"/>
Chronic lung problems	_____	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	_____	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble	_____	<input type="checkbox"/>	<input type="checkbox"/>
Stomach or bowel trouble	_____	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic pain	_____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	_____	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	_____	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder or arm pain	_____	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	_____	<input type="checkbox"/>	<input type="checkbox"/>
Hip or knee pain	_____	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pain	_____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	_____	<input type="checkbox"/>	<input type="checkbox"/>
Nervous system disorder	_____	<input type="checkbox"/>	<input type="checkbox"/>
Depression	_____	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness, panic attacks	_____	<input type="checkbox"/>	<input type="checkbox"/>
Trouble sleeping	_____	<input type="checkbox"/>	<input type="checkbox"/>
Liver or kidney trouble	_____	<input type="checkbox"/>	<input type="checkbox"/>

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Operations

Please list *all* operations with the date of the operation.

Operation

Date

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Hospitalizations

List the reason and month/year for hospitalizations in the past 10 years.

Reason

Month/Year

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Family History

Please indicate which family members have had any of the following medical conditions (give the relationship to you, not the relative's name).

<u>Condition</u>	<u>Family Member(s)</u>
<u>Diabetes</u>	_____
<u>Arthritis</u>	_____
<u>Depression</u>	_____
<u>Anxiety</u>	_____
<u>Nervous system problem</u>	_____
<u>Pain problems</u>	_____

Health Habits

If you ever smoked, how many packs per day and for how many years?

If you no longer smoke, when did you quit?

Have you ever used "street" drugs?

_____ **No** _____ **Yes**

Do you drink alcoholic beverages on most days?

_____ **No** _____ **Yes**

=> If yes, how many drinks per day, usually?

(1 drink is 1 beer, 6 oz of wine, or 2 oz of hard liquor)

Have you ever been a heavy drinker (6 drinks a day or more)?

_____ **No** _____ **Yes**

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Exercise History

In the last few months, how much time each week did you spend in at least moderate exercise?

Less than 15 min. **15 – 60 min.** **60 – 120 min.** **More than 120 min.**

Moderate exercise can be walking, bicycling, swimming, or heavy housework (vacuuming, cleaning). For example: 30 minutes per day, 3 days a week would be 90 minutes total for the week.

What kind of exercise activities do you engage in?

Social Support and Resources

1. How much help can you expect from family or friends when you are sick?

All I need **Daily help** **A few times a week** **Once a week** **Less than once**

2. Who is the person that usually helps you when you are sick?

3. Do you hire people to help you at home? Yes No

4. Do you have enough money to afford the little things that make life pleasant?

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Medication History

Please list all **prescription** medicines that you are currently taking.

<u>Name of Medication</u>	<u>Strength and Times per Day</u>

Please list all **over-the-counter** medicines that you are currently taking at least once a week.

<u>Name of Medication</u>	<u>Strength and Times per Day</u>

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Review of Symptoms

Have you been bothered by any of the following problems in the past few months? Please describe any problems briefly, with approximate dates. If you need more room, write on the back of the sheet. Leave the line empty if the problem has not occurred.

<u>Problem</u>	<u>Description, Date(s)</u>
Vision or hearing problem	_____
Lack of energy	_____
Decreased alertness and fatigue	_____
Dizziness and unsteadiness	_____
Passing out spells	_____
Falls or near falls	_____
Dry mouth	_____
Chest pain or discomfort	_____
Reflux or stomach pain	_____
Constipation	_____
Nausea	_____
Change in appetite	_____
Weight change	_____
Swelling	_____
Night sweats	_____
Trouble with sleep	_____
Depression	_____
Trouble with urination	_____
Confusion	_____
Sexuality problem(s)	_____