Invasive Pain Management Clinic

Patient Name:_____ What is your chief complaint / location of your pain? _____
Current Address:_____
Current Phone Number:_____ Any change in your medical history? _____
Have you had any surgeries since your last visit? Circle one: Yes No
List any new medications since your last visit_____

Constitutional

___ Chills
___ Fatigue
___ Weight Gain
___ Weight Loss

Cardiovascular

___ Chest Pain
___ Heart Attack
___ High Blood Pressure
___ Leg Swelling
___ Palpitations

Genitourinary

___ Frequency
___ Incontinence
___ Irregular Menses
___ Painful Urination
___ Urinary Infections

Neurological

___ Dizziness
___ Headaches
___ Loss of Balance
___ Nausea
___ Seizures
___ Stroke
___TIA

Psychiatric

___ Anxiety
___ Depression
___ Insomnia
___ Memory Loss
___ Nervousness

EYES

___ Blurred Vision
___ Double Vision
___ Eye Injury
___ Eye Surgery
___ Need of Glasses

Respiratory

___ Asthma
___ Cough
___ Shortness of Breath
___ Spitting Up Blood
___ Wheezing

Musculoskeletal

___ Injury
___ Joint Pain
___ Joint Stiffness
___ Spasm
___ Swelling
___ Weakness

Integumentary

___ Breast Discharge
___ Breast Lumps
___ Breast Pain
___ Nail Changes
___ Rashes
___ Ulcers

Endocrine

___ Diabetes
___ Excessive Thirst
___ Excessive Urination
___ Thyroid Problems

ENT

___ Hearing Loss
___ Ringing in Ears
___ Sores
___ Sinusitis
___ Swelling

Gastrointestinal

___ Bloody Stools
___ Loss of Appetite
___ Nausea
___ Vomiting

Infection

___ Hepatitis A
___ Hepatitis B
___ Hepatitis C
___ HIV / Aids

Hematological / Lymphatic

___ Bleeding Tendency
___ Blood Clots
___ Bruising Tendencies
___ DVT