PAIN THERAPEUTICS PROFESSIONAL ASSOCIATION

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HISTORY AND PHYSICAL

Patient's Name: _____ Date: _____

Tests Performed for Pain Problems

- ❑ X – RAYS
- ❑ CAT Scan
- ❑ MRI
- ❑ Bone Scan
- ❑ Discogram
- ❑ Myelogram
- ❑ Other _____

Medications

_____

_____

Drug Allergies: _____

_____

Past Medical History

_____

_____

_____

Hospitalizations (Date/Year of Problem Treated)

_____

_____

Review of Symptoms

_____

_____

Family Medical/Social History

Family Disease History: _____
How many people in household: _____
Smoker: _____**Yes** _____ **No / If yes, how much?** _____
Alcohol: _____**Yes** _____ **No / If yes, how much?** _____
Ever had a problem with alcohol? ___ Yes ___ No (DUI, injury, break-up)
If yes, when did you quit? _____

Patient's name: _____ Date: _____

Age: _____ Referring Physician: _____

Where is your worst pain? (Chief Complaint):

_____

_____

Please mark the areas you feel pain on the drawings. Put an "E" if it is external or an "I" if it is internal next to the areas that you have pain. Put an "EI" if the pain is both internal and external.