Orthopedic Associates
of Dutchess County
www.orthoadc.com

Pain Questionnaire

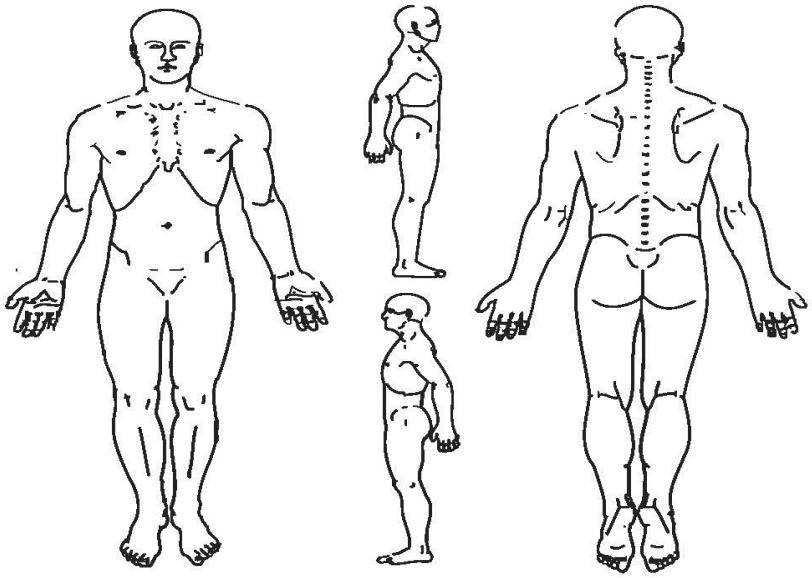
The purpose of this questionnaire is to obtain a complete assessment of you and your pain problems. This is a long questionnaire because pain is a very complex problem that affects all aspect of your life. We are trying to evaluate how the pain has affected your life so that we can make the best recommendation possible to assist you in your recovery. This record is confidential and no one can see it without your permission.

Patient's Name:_____ D.O.B.:_____ Age:__
Acct#:_____ Date:_____
Signature/Relationship of person completing this form:_____
Patient Address:_____ Phone (home):_____
_____
_____
Referring Physician's name and address: _____
Phone#:_____

Are you currently receiving or in the process of receiving worker's compensation related to your problem? YES NO

Pain Diagram

Pain: + + + Numbness: - - - Tingling: x x x



Patient's Name:_____ D.O.B.:_____ Age:_____Acct#:_____ Date:_____
Patient's Height:_____ Weight:_____

Pain History (Circle one that applies)	**Pain Intensity (Circle the one that applies)**
Throbbing, Shooting, Stabbing, Sharp, Cramping, Gnawing, Hot burning, Aching, Numbness, Tingling, Dull, Pulling	**0 1 2 3 4 5 6 7 8 9 10** 0= No Pain 5=Moderate Pain 10=Worst Pain Number your pain when it is worst: _____ Number your pain when it is least:_____ Number your pain on average: _____

When did the pain began? _____
How did your pain begin?_____
Briefly describe the circumstance when your pain began:_____
_____
In general, when is your pain the worst?
Morning _____ Afternoon_____Evening _____ Night_____ No pattern to the pain____
How often do you have the pain?
Constantly (100% of time) _____ Nearly constantly(60-90% of time)_____
Intermittent (30-60% of time) _____ Occasionally (less than 30% of time) _____

Please circle when your pain is felt:
Worse: Walking Lifting Bending Lying Weather changes Standing Other:_____
Better: Heat Ice Rest Lying Weather changes Standing Medication:_____

Prior Treatments (Check all that apply)

	Helpful	Not Helpful
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Diagnostic Procedure done

Diagnostic Test	**Body part evaluated**	**Date**
Plain X-Rays		
MRI		
CT Scan		
EMG		
Bone Scan		
Discogram		
Myelogram		

Patient's Name:_____ D.O.B.:_____ Age:_____Acct#:_____ Date:_____
Patient's Height:_____ Weight:_____

Past Medical History

- ☐ Heart Problems_____
- ☐ Hypertension_____
- ☐ Circulation Problems_____
- ☐ Diabetes_____
- ☐ Kidney/Bladder Problems_____
- ☐ Liver Problems_____
- ☐ Cancer_____
- ☐ Blood Disorders_____
- ☐ Lung Problems/Asthma_____
- ☐ Intestinal Problems/Ulcers_____
- ☐ Blackouts/Falls_____
- ☐ Other_____
- ☐ Any medical Devices implanted in your body?_____
  (i.e., pacemaker, portacath, pump, rods, prosthesis, etc.)

Past Surgical History

Name of Surgery	Date

Please list <u>all medication</u> and dosages you are currently taking. PLEASE DO NOT OMIT any blood thinners you may be taking; i.e., Coumadin, Lovenox, Heparin, Plavix, Aggranox, etc.

_____
_____
_____
_____

Please list all drug allergies

_____
_____
_____

Social History

Significant other: _____ Relationship: _____ Phone: _____
Do you take care of other family members:_____
Previous/Current Occupation:_____
Are you currently working? YES NO If not, why?_____
Do you have any legal issues that are current or pending related to your current medical problem? YES NO
If yes, please specify_____
Do you smoke? YES NO If yes, how many per day?_____
Recreational drug use? YES NO
Alcohol use? YES NO If yes, how many per day/week?_____

Patient's Name:_____ D.O.B.:_____ Age:_____Acct#:_____ Date:_____
Patient's Height:_____ Weight:_____

Family History

Do you have a family history of the following? Please circle the ones that apply.

Pain Arthritis Cancer Psychological problems Bleeding disorder Other_____

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Patient's review of systems (Circle all that apply to you)

Eyes: Eyeglasses Cataracts Glaucoma Contacts Other:
Skin: Rashes Dermatitis Psoriasis Eczema Other:
Ear/Nose Throat: Deafness Allergies Sinus Trouble Nosebleeds Chronic Sinus Infections Difficulty Swallowing Other:
Neurologic: Stroke Dizziness Numbness Fainting Seizure Headaches Blackout/Falls Other:
Infectious Disease: HIV Infection Hepatitis Lyme Disease Other:
Heart & Cardiovascular: Chest Pain Heart Disease Blood Clots Rheumatic Fever Heart Attack Hypertension Arrhythmia Murmurs Palpitations Hypotension Varicose Veins PE (Pulmonary Embolism) Circulation Problems Other:
Endocrine: Thyroid Excessive Hunger or Thirst Excessive Sweating Diabetes Other:
Genitourinary: Frequent Urination Burning or Pain Hematuria Prostate Problem Bladder Incontinence Other:
Pulmonary/Respiratory: Emphysema Wheezing SOB (Shortness Of Breath) Sleep Apnea COPD Other:
Hematological/Lymphatic: Lymphedema Easy Bleeding Easy Bruising Hematologic Disorder Other:
Psychologic: Mood Changes Sad or Feeling Down Confused Depression Anxiety Other:
Gastrointestinal: Bloating Nausea Constipation Reflux Vomiting Jaundice Abdominal Pain Other:
Constitutional: Fever Anorexia Night Sweats Chills Weight Loss Fatigue Other:
OBGYN: ☐Pregnant ☐Ovarian Cancer ☐Cysts ☐Endometriosis Other:
Musculoskeletal: Rheumatoid Back Pain Muscle Pain Joint Pain Neck Pain Leg Pain Gout Osteoporosis Weakness Other:
OTHER: