



Metro Denver Pain Management

1260 S. Parker Rd. Ste. 200
Denver, CO 80231

Christopher J. Huser, M.D.
Kevin T. Smith, M.D.

QUESTIONNAIRE TO BE FILLED IN BY ALL NEW PATIENTS

NAME: _____

DATE: _____

Age: _____ Sex: Male Female

Marital Status: Single Married Divorced Widowed

Employment Status: Full Time Part Time Unable to Work Retired

Disabled/Reason for Disability: _____

Occupation: _____

Nature of your Problem: _____

How do you describe your pain (i.e. stabbing, pins and needles, etc.)? _____

To the best of your understanding, what is the cause of your pain? _____
Is your pain related to an injury Yes No (If yes, please describe) _____

How long have you had this problem? _____

What physician(s), Surgeon(s) have you seen for treatment of your pain? _____

What other treatment options have you tried? (physical therapy, alternative therapy, blocks, etc.) _____
_____ Which were effective? _____

What medication(s) do you currently take for pain? Are they effective? _____

What medication(s) have you tried that were not effective or may have caused side effects? _____

What things do you do (or can do) to bring on the pain? _____

What things do you do (or can do) to lessen the pain? _____

Do you engage in physical activity daily/weekly? If so, explain: _____

Do you have numbness of your skin? Yes No If yes, where? _____

Do you have weakness of your muscles? Yes No If yes, where? _____

How many times have you been to an ER or urgent care clinic in the past 6 months for the treatment of pain?

What are your expectations of how we can help you? _____

Circle the corresponding number (1-10) to show how far from normal toward the worst possible situation your pain has caused you to be. The left side of each line is the “best” or “normal” situation and the right side of the line is the “worst” it could be.

Severity of your pain (average):

None 1 2 3 4 5 6 7 8 9 10 severe/worst

To what extent do you need to use pain medications?

Never 1 2 3 4 5 6 7 8 9 10 More than recommended/Prescribed

What is the effect of the pain on your work (please take into account absence from work or interfering with work abilities, etc.)?

None 1 2 3 4 5 6 7 8 9 10 Unable to work

How does the pain affect your need for help with daily activities (household chores and personal care?)

None 1 2 3 4 5 6 7 8 9 10 Need total assistance

Effect of your pain on your mood (depression/anxiety):

None 1 2 3 4 5 6 7 8 9 10 Severe

How much does the pain interfere with your sleep?

None 1 2 3 4 5 6 7 8 9 10 Cannot sleep at all

Effect of pain on your lifestyle (i.e. social, sports, hobbies, etc.):

None 1 2 3 4 5 6 7 8 9 10 Severe

How much do you feel your pain has changed your relationships with others?

No change 1 2 3 4 5 6 7 8 9 10 Drastic Change

Do you have allergies to Medications? Yes No If yes, please list _____

Please list all medications you currently take: _____

Prior surgeries (& year): _____

Anesthesia Complications/Problems: _____

Family Hx: _____

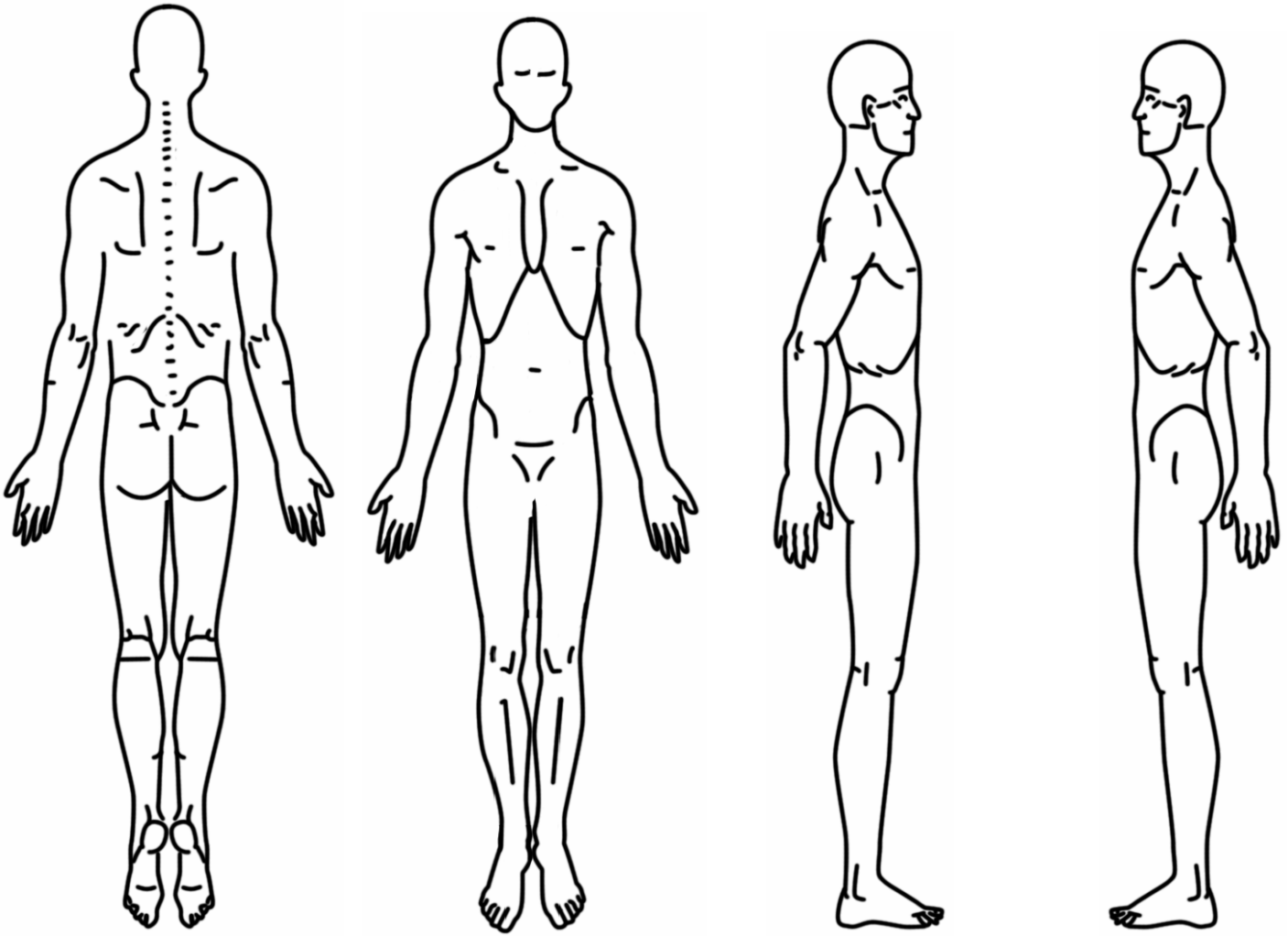
REVIEW OF SYSTEMS & MEDICAL ILLNESSES

Please check either Yes or No to the following:

<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">Constitutional Symptoms:</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Weight Changes</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Fever or Chills</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Cancer or tumors</td> </tr> <tr> <td colspan="2"> </td> </tr> <tr> <td colspan="2">Genitourinary</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>frequent urine infections</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Kidney disease</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>loss of urine control</td> </tr> <tr> <td colspan="2">How often do you get up at night to void?</td> </tr> <tr> <td colspan="2"> </td> </tr> <tr> <td colspan="2">Eyes, ears, nose, mouth throat</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Visual changes</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>hearing loss</td> </tr> <tr> <td colspan="2">Cardiovascular</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>heart disease</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>hypertension</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>rheumatic fever</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>chest pain (angina)</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>heart attack</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>irregular heart beat</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>heart murmur</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>leg swelling</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>blood clots in legs</td> </tr> <tr> <td colspan="2">Respiratory</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>pneumonia</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>emphysema</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>tuberculosis</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>chronic obstructive disease</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>asthma</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>shortness of breath</td> </tr> <tr> <td colspan="2"> </td> </tr> <tr> <td colspan="2">Gastrointestinal</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>frequent heart burn/reflux</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>nausea and vomiting</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>hepatitis or cirrhosis</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>constipation</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>ulcers</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>change in bowel movements</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>bloody bowel movements</td> </tr> <tr> <td colspan="2"> </td> </tr> <tr> <td colspan="2">Other Illnesses</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Do you Smoke cigarettes? 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<input type="checkbox"/> Yes <input type="checkbox"/> No Do you consume alcoholic beverages? If yes, how many per day _____

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Using the figures above, mark the locations of your pain.

Indicate an **X** for Stabbing or Burning Pain; Use a **Z** to indicate Tingling; and Use an **N** for Numbness

Also indicate if the pain radiates to any other part of your body, by placing arrows from where the pain originates to where it goes.

Patient Signature

Date