

ADVANCED PAIN CENTERS OF ALASKA

Patient History

DATE: _____	AGE: _____
NAME: _____	
Male / Female	Right Handed / Left Handed
Please describe your injury/illness:	

Please circle all that you have been treated for:

HEART: Chest Pain Palpitations Heart Failure Pacemaker
Irregular Heart Rate Valve Replacement Hypertension
Hypercholesterol Phlebitis Cellulitis Lymphedema
Coronary Artery Disease Bypass Surgery Catherization
Angioplasty Stent Placement _____

LUNGS: Shortness of Breath Emphysema Pneumonia
Asthma Pulmonary Embolism _____

GASTROINTESTINAL: Reflux Disease Hiatal Hernia
Hemorrhoids Abdominal Aortic Aneurysm Gallstones
Gallbladder Removal Appendectomy Colon Resection
Hepatitis Bowel Incontinence _____

GENITOURINARY: Frequent Urinary Tract Infections
Kidney Stones Enlarged Prostate Indwelling Catheter
Bladder Incontinence Prostate Surgery Hysterectomy

NEUROLOGICAL: Stroke Traumatic Brain Injury
Closed Head Injury Intracranial Hemorrhage Herniated Disc
Carpal Tunnel Syndrome Sciatica Limb Numbness/Tingling

MUSCULOSKELETAL: Fractures Osteoarthritis Neck Pain
Rheumatoid Arthritis Osteoporosis Low Back Pain Scoliosis
Disc Disease _____

ENDOCRINE: Diabetes Hypothyroid _____

MENTAL HEALTH: Depression Anxiety Bipolar Disorder
Panic Attacks Schizophrenia _____

CANCER: Location: _____
Surgery: _____
Chemo: Yes / No Radiation: Yes / No

MEDICATIONS:

MEDICINE ALLERGIES: None

SOCIAL HISTORY:

Patient Lives with: Spouse / Parents / Son / Daughter / Alone
Lives in a ____ Story House / Apartment / Townhouse /
Mobile Home
____ Assisted Living Facility ____ Nursing Home
____ Steps to Enter House ____ Ramp ____ Elevator
____ Steps to the Second Floor
Bedroom and Bathroom on the First Floor: Yes / No
Occupation: _____
____ Currently Working ____ Not Working ____ Retired
Smoking: Yes / No ____ Packs Per Day x ____ Years
Stopped Smoking ____ Years Ago
Alcohol: Yes / No Daily / Socially

FAMILY HISTORY:

<u>Family Member</u>	<u>Medical History Of</u>
_____	_____
_____	_____

FUNCTIONAL HISTORY:

Do you need help with the following:

Yes	No	
_____	_____	Getting In/Out of bed
_____	_____	Feeding Yourself
_____	_____	Upper Body Dressing
_____	_____	Lower Body Dressing
_____	_____	Grooming Yourself
_____	_____	Bathing Yourself
_____	_____	Toileting
_____	_____	Getting In/Out of Chairs
_____	_____	Getting In/Out of Tub or Shower

Equipment Used For Walking: Cane Wheelchair Walker

REVIEW OF SYMPTOMS: (Please circle all that apply)

Cons: Fever Chills Weakness Insomnia Fatigue
Eyes: Glasses Blurred Vision Double Vision
ENT: Hearing Aid Tinnitus
CVS: Chest Pain Palpitations DOE
Resp: SOB Cough
GI: Nausea Vomiting Diarrhea Constipation Incontinence
GU: Burning Retention Incontinence
Musc: Pain Weakness Decreased ROM
Neuro: Numbness Tingling Burning "Pins & Needles"
Psych: Depression Anxiety
Skin: Rash Ulceration Surgical Wound
Lymph / Heme: Swollen Glands Increased Bruising or Bleeding
Other: _____

PRIMARY CARE DR.: _____

OTHER DOCTORS YOU SEE: _____
