PAIN CONSULTANTS & INTERVENTION- EDWARD POON, MD

3860 Masthead Street N.E., Albuquerque, NM 87109

TODAY'S DATE____________

Patient Information

Last Name	First Name	MI	DOB	Age

Home Address	City	State	Zip	**FULL** Social Security # (required)

( ) Day Phone	( ) Evening Phone	( ) For emergency please call – Name, Phone	**Email** (required)

Primary Medical Insurance Carrier	Secondary Medical Insurance Carrier

Name of Employer If This Is A Work Injury	Employer's Phone Number If This Is A Work Injury

Primary Physician's Name	( ) Phone Number	Referring Physician's Name	( ) Phone Number

I learn best by: ☐ Verbal Instruction ☐ Visual Demonstration ☐ Written Instruction ☐ Hands On ☐ Any Of These

Chief Complaint

Please describe your **primary pain problem** today: ____

____

Does your **pain radiate**? ☐ Yes ☐ No If so, please describe: ______________________________

____

When did your **pain first begin**? ______________ What **caused the pain**? (e.g. accident, injury, etc.)____________________

On the diagram below please circle the number that best indicates the **severity of your pain.**

NO PAIN **DISTRESSING PAIN** **UNBEARABLE PAIN**

0 1 2 3 4 5 6 7 8 9 10

Please **describe your pain**, check all that apply:
☐ Aching ☐ Burning ☐ Dull ☐ Numbness ☐ Pulling ☐ Sharp ☐ Shooting ☐ Stabbing
☐ Throbbing ☐ Tingling ☐ Other *describe*: ______________________________

How **often** do you have your pain?
☐ Constantly: 80-100% of the time ☐ Nearly constantly 50-80% of the time ☐ Intermittently 25-50% of the time
☐ Occasionally 25% of the time or less

In general, when is **your pain the worst**? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ No typical pattern

Please check what makes your **pain feel worse**:
☐ Walking ☐ Lifting ☐ Bending ☐ Lying ☐ Standing ☐ Sitting ☐ Rest ☐ Exercise
☐ Touch ☐ Heat ☐ Cold ☐ Weather changes ☐ Temperature Changes
☐ Other *describe:* ______________________________

Please check what makes your **pain feel better**:
☐ Walking ☐ Lifting ☐ Bending ☐ Lying ☐ Standing ☐ Sitting ☐ Rest ☐ Exercise
☐ Touch ☐ Heat ☐ Cold ☐ Weather changes ☐ Temperature Changes
☐ Other *describe:* ______________________________

Please See Next Page

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Complaint

Have you had **involuntary loss of bowel or bladder control**? ☐ Yes ☐ No

Do you experience any **weakness with your pain**? ☐ Yes ☐ No

Please describe any **significant interference** that your pain causes in your **daily activities** (e.g. walking, sleeping, appetite, chores, etc.):

____

Studies

Have you had any of the following **tests for this pain problem**?

	Ordering Doctor	Date	Facility
☐ MRI			
☐ CAT Scan			
☐ X-Ray			
☐ EMG			

Treatments

Please list any **injections that you've had for this pain problem**:

Injection	Doctor	Date

Please list **ALL surgeries that you've had**:

Surgery	Surgeon	Date

Other *describe:* ____

Past Medical History

Please check any of the following that you have and put the date diagnosed: **(Do your parents have these diagnoses/illness? + or -)**

☐ Heart Attack Date:_______ (Parents:)	☐ Hypertension Date:_______ (Parents:)	☐ Vascular Disease Date:__________
☐ Stroke Date:_______ (Parents:)	☐ Hepatitis Date:_______ (Parents:)	☐ Cancer, where?__________ (Parents:)
☐ Diabetes Date:_______ (Parents:)	☐ Ulcer Date:_______ (Parents:)	☐ Dementia Date:__________
☐ Headaches Date:_______ (Parents:)	☐ GI Bleed Date:_______ (Parents: _)	☐ Kidney Failure Date:__________
☐ Blood Clots Date:_______ (Parents:)	☐ COPD Date:_______ (Parents:)	☐ Joint Pain, where?__________________
☐ Falls Date:______	☐ Asthma Date:_______ (Parents:)	☐ Fractures, where?__________________

Please check any of the following:

☐ Tobacco Use	☐ Type: ________________	☐ Amount Per Day: ____________	☐ Number of Years: _______
☐ Alcohol Use	☐ Type: ________________	☐ Amount Per Day: ____________	☐ Number of Years: _______
☐ Recreational Drug Use	☐ Type: ________________	☐ Amount Per Day: ____________	☐ Number of Years: _______

Medications

Please list your **current medications**. Include over the counter medications.

Name of Medication	Prescribing Doctor	Dose	Frequency	Date Started

Other

ALLERGIES		BLOOD THINNERS		IMPLANTS	
☐ No Allergies	☐ Contrast Dye	☐ Heparin	☐ Coumadin	☐ Pacemaker	☐ Portacath
☐ Iodine	☐ Shellfish	☐ Lovenox	☐ Ticlid	☐ Pump	☐ Rods
☐ Betadine	☐ Alcohol	☐ Plavix		☐ Prosthesis	
☐ Medications *List*: ____________		☐ Other *List*: ________________		☐ Other *List*: ________________	
____________________________		____________________________		____________________________	
____________________________		____________________________		____________________________	

COGNITION

Have you changed in the last several years caused by memory problems below:

Reduced interest in hobbies/activities: ☐ Yes ☐ No ☐ Don't know	Forgets correct month or year: ☐ Yes ☐ No ☐ Don't know
Judgment problems (falls for scams, bad financial decisions, buy inappropriate gifts): ☐ Yes ☐ No ☐ Don't know	Difficulty handling complicated financial affairs (balancing checkbook, paying bills or tax): ☐ Yes ☐ No ☐ Don't know
Repeats questions, stories, or statements: ☐ Yes ☐ No ☐ Don't know	Trouble learning to use a tool, appliance, gadget: ☐ Yes ☐ No ☐ Don't know
Difficulty remembering appointments: ☐ Yes ☐ No ☐ Don't know	Consistent problems with thinking or memory: ☐ Yes ☐ No ☐ Don't know