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 | Height | Weight

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 / ID # | Secondary Medical Insurance Carrier / ID #

Name of Employer If This Is A Work Injury | Employer's Phone # If This Is A Work Injury | Preferred Pharmacy / Cross Streets

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

☐ No Allergies ☐ Contrast Dye
☐ Iodine ☐ Shellfish
☐ Betadine ☐ Alcohol
☐ Medications *List*: _____

BLOOD THINNERS

☐ Heparin ☐ Coumadin
☐ Lovenox ☐ Ticlid
☐ Plavix
☐ Other *List*: _____

IMPLANTS

☐ Pacemaker ☐ Portacath
☐ Pump ☐ Rods
☐ Prosthesis
☐ 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