Wellstar North Fulton Hospital Pain & Spine Center
New Patient Questionnaire

Patient Name _____ Today's Date _____

Birthdate_____ Age_____

Referring Doctor _____Internist/Family Doctor_____

Cardiologist/Vascular_____Neurologist_____

Have you seen a Pain Doctor before? **Yes / No** If yes, provide name and practice_____

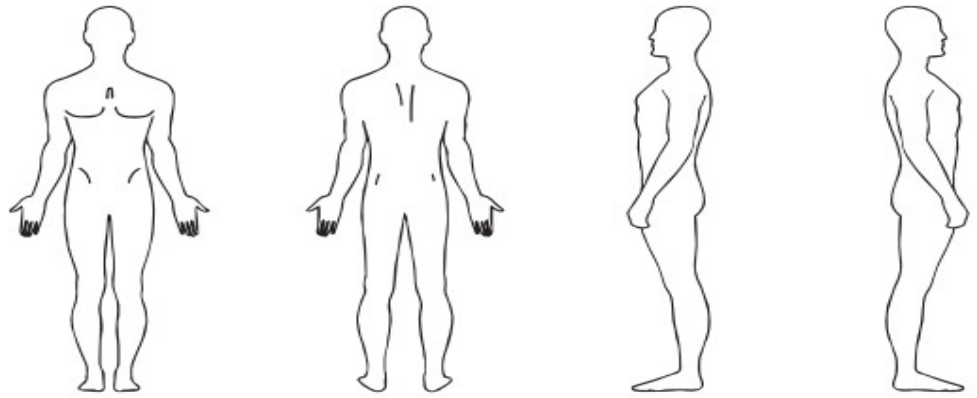
_____

How long has your pain been present? _____

Is your pain from an injury or accident? **Yes / No** If yes, briefly describe what happened _____

_____

On the diagram below, please indicate where you are experiencing pain right now.



Does it travel or radiate? **Yes / No** If yes, where to? _____

Describe your pain	**What makes your pain WORSE?**	**What makes your pain BETTER?**
☐ Aching	☐ Bending	☐ Exercise
☐ Burning	☐ Climbing stairs	☐ Heat/Ice
☐ Dull	☐ Going down stairs	☐ Lying down
☐ Pins & Needles	☐ Lifting	☐ Massage
☐ Numbness	☐ Lying down	☐ Pain/Prescription meds
☐ Shooting	☐ Pushing a shopping cart	☐ Pushing a shopping cart
☐ Stabbing	☐ Sitting	☐ Sitting
☐ Throbbing	☐ Standing	☐ Standing
☐ Other	☐ Walking	☐ Walking
	☐ Other_____	☐ Other_____

Circle AVERAGE pain level on a **GOOD** day: 0 1 2 3 4 5 6 7 8 9 10
Circle AVERAGE pain level on a **BAD** day: 0 1 2 3 4 5 6 7 8 9 10

Are your current **pain** medications causing any side effects? **Yes / No / N/A**

If yes, please list _____

Are your current medications for this **pain** increasing your ability to function? **Yes / No / N/A**

If yes, describe how they increase your function? _____

CIRCLE Previous Treatments below that you have tried for your **current pain**

TREATMENT	HELPED ?	DATE	TREATMENT	HELPED ?	DATE
Ice Packs	Y / N		Chiropractor	Y / N	
Heating Pad	Y / N		Massage	Y / N	
Injection: Epidural	Y / N		Acupuncture	Y / N	
Injection: Trigger Point	Y / N		Spinal Cord Stimulator	Y / N	
Injection: Other	Y / N		TENS Unit	Y / N	
Opioids (oxycodone, hydrocodone, etc.)	Y / N		**Ibuprofen, Motrin, Aleve, Tylenol, etc.**	Y / N	
Physical Therapy (# of sessions/Duration)	Y / N	*	OTHER	Y / N	

Are you **Diabetic**? **Yes / No**

Are you currently taking any **Blood Thinners**? **Yes / No** If yes, please list_____

Are you ALLERGIC to any of the following? If Yes, list reaction below.

Betadine Yes / No		Latex Yes / No
CT/Contrast Dye Yes / No		Lidocaine/Marcaine Yes / No
Steroids Yes / No		

Are you ALLERGIC to any Medications Yes / No (If Yes, list medication and reaction below)

Medication	Reaction		Medication	Reaction

Pharmacy Name_____ **City**_____ **Phone**_____

CURRENT MEDICATIONS (Attach list as needed)

Medication Name	Dose	Times per Day		Medication Name	Dose	Times per Day

Medical History

❑ Abnormal ECG	❑ Concussion	❑ Headaches	❑ Pancreatitis
❑ Alcoholism	❑ Conversion Disorder	❑ Hepatitis	❑ Psychosis
❑ Anemia	❑ COPD	❑ History of Blood Transfusion	❑ Pulmonary Artery Hypertension
❑ Aneurysm	❑ Coronary Artery Disease	❑ HIV/AIDS	❑ PVD
❑ Anxiety	❑ Deep Vein Thrombosis	❑ Hyperlipidemia	❑ Rheumatoid Arthritis
❑ A-V Malformation	❑ Depression	❑ Hypertension	❑ Schizophrenia
❑ Bipolar Disorder	❑ Diabetes Mellitus	❑ Kidney Disease	❑ Seizures
❑ Cancer	❑ Disc problem- Cervical	❑ Liver Disease	❑ Sickle Cell Anemia
❑ Carotid Disease	❑ Disc problem – Lumbar	❑ Low Back Pain	❑ Sleep Apnea
❑ CHF	❑ Disc problem- Thoracic	❑ Myocardial Infarction	❑ Stroke
❑ Cirrhosis	❑ Fatigue	❑ Neuropathy	❑ Substance Abuse
❑ Clotting Disorder	❑ Fibromyalgia	❑ Osteoarthritis	❑ TIA

Other Medical History: _____

_____

_____

Surgical History

Surgery	Date		Surgery	Date

Do you drink alcohol? **Yes / No** Wine / Beer / Shots of Liquor How many per week?_____

Do you use any recreational drugs? (marijuana, cocaine, heroin, etc) **Yes / No** Please list:_____

Tobacco use: **Current/Former/Never** Packs per day _____Number of years_____ Quit Date_____

Smokeless Tobacco use: **Current/Former/Never** Quit Date_____

Over the last 2 weeks how often have you been bothered by the following:

Little interest or pleasure in doing things: •Not at all •Several Days •More than half the days •Nearly every day

Feeling down, depressed or hopeless: •Not at all •Several days •More than half the days •Nearly every day

Patient Signature_____ Date/ Time _____

Reviewed by _____RN Date/ Time _____