Community Memorial Healthcenter **PAIN MANAGEMENT** SERVICES, LLC

Please check all of the following that apply to *YOUR MEDICAL* history:
Please check all that apply

Cardiovascular:
- ☐ Hypertension
- ☐ Pacemaker
- ☐ Blood Clots
- ☐ Aortic Stenosis
- ☐ Irregular Heart Rhythm
- ☐ Chest Pain
- ☐ Cardiac Catheter
- ☐ Stroke
- ☐ Mitral Stenosis
- ☐ Heart Attack
- ☐ Angioplasty
- ☐ Murmur
- ☐ Congestive Heart Failure
- ☐ Mitral Prolapse

Pulmonary: ☐ Asthma ☐ Emphysema ☐ Tuberculosis ☐ Pulmonary Embolus

Gastro-Intestinal: ☐ Hiatal Hernia ☐ Ulcer ☐ Bowel Obstruction ☐ Diverticulitis ☐ Heartburn

Hepatic: ☐ Hepatitis ☐ AIDS ☐ **Cancer:** Type :_____

Renal: ☐ Urinary Infection ☐ Renal Failure ☐ Dialysis ☐ Kidney Stones

Neurologic: ☐ Seizures ☐ Paralysis ☐ Meningitis ☐ Suicidal Thinking ☐ Congenital Abnormalities ☐ Migraines ☐ Depression

Orthopedic: ☐ Broken bones ☐ Amputation ☐ Spine Surgery

Metabolic: ☐ Diabetes ☐ Changes in Thyroid or parathyroid Function ☐ Weight Gain ☐ Weight Loss

Reproductive: ☐ Possibility of Pregnancy ☐ Heavy Menstrual Flow ☐ Past-menopausal bleeding ☐ Impotence

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Please list any healthcare providers that have treated you for this pain

_____

Have you had any injections for your pain? **Yes**☐ **No** ☐

if so did they help **Yes**☐ **No** ☐

Medications you are currently taking:

_____

_____

_____

_____

_____

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Medications you have taken in past that helped:

_____

_____

_____

Have you tried Motrin/Ibuprofen? **Yes**_____ **No**_____ Mobic **Yes**_____ **No**_____

Physical Therapy **Yes**_____**No**_____ Soma **Yes**_____ **No**_____

Ice/Heat **Yes**_____**No**_____ Muscle Relaxers **Yes**_____ **No**_____

Have you had x-rays, MRI, CT scan if so where/when? _____

Medications taken in past that **did not** help: _____

_____

Do you have any Drug Allergies? Yes _____ No _____ if so what are they? _____

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