# Advanced Pain & Spine Management, S.C.

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Name _____Temp: _____ DOB: _____/_____/_____

Address _____

City/State/Zip _____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Email _____@_____

Do you want access to our Patient Portal? ____Yes _____No (need email address)

I DO/DO NOT (circle one) consent to receive _____voice _____text _____email messages for appointment reminders. Patient signature _____

Do you consent to us having access to your prescription records? _____Yes _____No

Referring Doctor _____ Phone _____

Primary Doctor _____ Phone _____

Preferred Pharmacy _____ Zip Code _____

Address _____ City/State _____

Primary Insurance _____

Cardholder name_____ DOB: _____/_____/_____

Secondary Insurance _____ **OVER →**

**OFFICE USE ONLY*****

**DIAGNOSIS:** _____

**ORDERS:** _____

_____

_____

**REFERRALS:** _____

**MEDICATIONS:** _____

_____

***Are you currently involved in any litigation regarding your health problems?*** _____Yes _____No

**SOCIAL HISTORY:**

1. Do you smoke? ___No ___Yes Cigarettes Cigar Pipe Vaping How much/day? _____
   Past smoker? ___ No ___ Yes When Quit _____
2. Do you consume alcohol? ___No ___Yes How often? _____ What? _____
3. Occupation _____
4. Marital status ___ Single ___ Married ___Divorced ___Widow
5. Any children? ___No ___Yes If yes, how many? _____

| **FAMILY HISTORY:** | | **MOTHER** | **FATHER** |
|---|---|---|---|
| Any family history of: | Diabetes | _____ | _____ |
| | High Blood Pressure | _____ | _____ |
| | Asthma | _____ | _____ |
| | Heart Disease | _____ | _____ |
| | Cancer (type) | _____ | _____ |
| Other: | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**MEDICAL HISTORY:**

| | | | |
|---|---|---|---|
| Any history (past or present) of: | ___ Diabetes | ___ High Blood Pressure | ___ COPD |
| | ___ Heart Disease | ___ Asthma | ___ Seizures |
| Other: _____ | ___ Osteoarthritis | ___ Rheumatoid Arthritis | ___Drug Abuse |
| _____ | ___ Alcohol Abuse | ___ Sexual Abuse | ___ Kidney Disease |
| _____ | ___ Mental Illness | ___ Depression | ___ Anxiety |
| _____ | ___ Cancer (details _____ | | |

Have you ever had a blood transfusion? ___ No ___ Yes

**Do you take any blood THINNERS? ___ No ___ Yes If yes, name_____**

Have you had any major surgeries? _____

_____

_____

**Do you have any allergies to medications? ___ No ___ Yes Please list: _____**

**_____**

**Are you allergic to any of the following: _____ No**

**_____ Latex _____ Steroids _____ Dye _____ Adhesives (band-aids)**

**_____ Lidocaine/Marcaine/Bupivicaine/Novocaine**

**Do you have any of the following symptoms?**

___ Chills
___ Fatigue
___ Fever
___ Night sweats
___ Recent weight change
___ Tinnitus
___ Hearing problems
___ Nasal congestion
___ Rhinorrhea (frequent runny nose)
___ Sore throat
___ Blurred vision
___ Sensitivity to light
___ Glasses/Contacts
___ Cough
___ Shortness of breath
___ Wheezing
___ Skin problems
___ Abdominal pain
___ Constipation
___ Diarrhea
___ Nausea
___ Vomiting
___ Heartburn/indigestion
___ Painful urination
___ Blood in urine
___ Urinating during night 2+times
___ Frequent urination (daytime)
___ Chest pain
___ Palpitations
___ Tachycardia
___ Dizziness
___ Fainting
___ Headaches
___ Migraines
___ Memory loss
___ Numbness/tingling
___ Weakness
___ Paralysis
___ Seizures
___ Tremors
___ Vertigo
___ Neck/shoulder pain
___ Easy bruising
___ Excessive bleeding
___ Swelling of hands/feet
___ Joint swelling
___ Joint pain
___ Difficulty walking 2 blocks
___ Excessive thirst
___ Feeling stressed

**Tell me about your pain:**

___ Achy ___ Throbbing ___ Burning ___ Sharp ___ Stabbing ___ Painful to touch

**MEDICATION LIST (please list all medications & dosages you currently take)**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

## ***OFFICE USE ONLY***

Height _____ Weight _____ Pain Level _____/10 BP _____/_____ HR _____ spO2 _____%

CC: _____

_____

_____

_____

_____

_____

_____