Boston Medical Center
One Boston Medical Center Place
Boston, MA 02118
Telephone: (617) 638-6965

New England Pain Management Consultants

At Boston Medical Center

INITIAL PAIN MANAGEMENT PATIENT QUESTIONNAIRE

Dear New Pain Management Patient,

Welcome to the New England Pain Management Consultants Pain Clinic at Boston Medical Center. Please take a few moments to carefully and completely fill out the following questions regarding your pain history and medical history. Accurate completion of this form is important, so please ask the receptionist or the nurse if you have any questions. When choices are given, circle the answer that is correct.

At New England Pain Management Consultants, your time is important to us. We greatly appreciate your arriving on time and we will always do our best to stay on schedule so that you don't have to wait for your appointment. Occasionally, we do get behind schedule because of emergencies or because prior patients have required more time for their appointments than we had anticipated. In the event that this happens, please be assured that you will be seen as soon as possible and always in the order in which you were scheduled.

Thank You,

The Pain Clinic Staff of
Boston Medical Center

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Please list the following:

REFERRING PHYSICIAN: _____

PRIMARY CARE PHYSICIAN: _____

CHIEF COMPLAINT:

Please briefly state the reason you are here today. For example: low back pain, headache, right shoulder pain, etc. _____

HISTORY OR PRESENT ILLNESS:

When did your pain first start? _____

How did your pain start? _____

Was it the result of an accident or injury? ☐ YES ☐ NO

Were you injured at work? ☐ YES ☐ NO

Are you involved in litigation (Lawsuit)? ☐ YES ☐ NO

Is Worker's Compensation involved in injury? ☐ YES ☐ NO

What part of your body hurts the most? _____

Does the pain radiate from this part of your body to another area? ☐ YES ☐ NO

If yes, where? _____

Describe the quality of the pain; circle all of the words that apply. Sharp Burning Dull Aching

Is your pain constant or intermittent? Constant Intermittent

If your pain is intermittent, is there a time of the day when your pain is usually worse or better? Worse _____ AM / PM Better _____ AM / PM

Are there activities that make your pain worse (For example: walking, sitting, stair climbing, etc.) _____

What makes your pain better? _____

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DIAGNOSTIC TESTS:
Have you had any of the following to help diagnose your pain problem?

1. Plain X-rays: ☐ YES ☐ NO
   Date: ____/____/____
   What X-ray facility? _____

2. CT Scans: ☐ YES ☐ NO
   Date: / /
   What X-ray facility? _____

3. MRI Scans: ☐ YES ☐ NO
   Date: / /
   What X-ray facility? _____

PAIN MEDICATIONS:
Please list any pain medications that you are taking now or have taken in the past to treat your pain. Non-pain medicines should be listed of page 4.

Pain Medication	Amount	Has it helped?		Prescribed by:
		☐ YES	☐ NO	
		☐ YES	☐ NO	
		☐ YES	☐ NO	
		☐ YES	☐ NO	
		☐ YES	☐ NO	
		☐ YES	☐ NO	
		☐ YES	☐ NO	

PAST MEDICAL HISTORY:
Do you have a history of any of the following?

Chest Pain	☐ YES	☐ NO	Stroke	☐ YES	☐ NO
Heart Attack	☐ YES	☐ NO	Ulcer Disease	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO	Diabetes	☐ YES	☐ NO
Congestive Heart Failure	☐ YES	☐ NO	Thyroid Disease	☐ YES	☐ NO
Abnormal Heart Rhythm	☐ YES	☐ NO	Anemia	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Bleeding Disorders	☐ YES	☐ NO
Pneumonia	☐ YES	☐ NO	Arthritis	☐ YES	☐ NO
Kidney Failure	☐ YES	☐ NO	Psychiatric Disorders	☐ YES	☐ NO
Prostate Trouble	☐ YES	☐ NO	Cancer	☐ YES	☐ NO
Liver Failure	☐ YES	☐ NO	Hepatitis	☐ YES	☐ NO
Seizures	☐ YES	☐ NO	Are You Pregnant	☐ YES	☐ NO
	☐ YES	☐ NO		☐ YES	☐ NO
	☐ YES	☐ NO		☐ YES	☐ NO

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PAST SURGICAL HISTORY
Please list any surgical procedures that you have had and the date of the surgery.

☐ Check this box if you have never had surgery.

Surgery	Date of Operation

CURRENT MEDICATIONS: (Don't list pain medications here. Pain medications should be listed on page 3.)

Medication	Amount (Mg)	Frequency	What is it for?

ALLERGIES:
Please list any medications that you are allergic to and the adverse reaction that you have.

☐ Check if you have no known drug allergies

Medication:	Adverse Reaction:

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SOCIAL HISTORY:

Marital Status: Single Married Divorced Widowed Committed Relationship

Work Status: Working Not working Retired Disabled

Occupation: _____

Disability: Temporary Permanent

Reason for Disability: _____

If you are not currently working, do you plan to return to work? ☐ YES ☐ NO

FAMILY HISTORY: Please list any diseases that run in your family.
(for example: diabetes, heart disease, cancer, etc.)

_____

REVIEW OF SYSTEMS:

Have you ever been a smoker? ☐ YES ☐ NO
If yes, do you still smoke? ☐ YES ☐ NO
How many packs a day do you smoke? _____
If no, what year did you quit? _____

Do you drink alcohol? ☐ YES ☐ NO
If yes, how many drinks / day? _____
Have you ever had a problem with alcohol? ☐ YES ☐ NO
Do you have a history of using marijuana, cocaine, heroin or other illegal drugs? ☐ YES ☐ NO
If yes, which drugs? _____

_____
Patient Name

_____ _____
Signature Date

THIS IS THE END OF THE PATIENT SECTION, THE REST OF THE INFORMATION WILL BE FILLED IN BY YOUR NURSE AND DOCTOR.

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PHYSICAL EXAM

Height _____ Ft. _____ In. Weight _____ Lbs. BP ____ / ____

ADDITIONAL COMMENTS:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____
Nurse's Signature (if applicable) Date

_____ _____
Physician Signature Date