CONFIDENTIAL
University of Florida Pain Center
Health Questionnaire

Thank you for arranging to visit one of our physicians.

When you come for your first visit, **please bring this <u>completed</u> form** along with any medical records, X-rays, CT or **MRI** scans, medication bottles and other medical information related to the problem for which you are being seen. Should you have any questions, please do not hesitate to contact us.

Thank you very much. We look forward to seeing you.

Please complete the attached questionnaire before your appointment. It is confidential and will be part of your medical record. It asks for information about your current problems and your past medical history. This form will give your doctor a better understanding of your problem, and will allow him or her to spend more time discussing treatment plans with you.

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Name: ____
City: ______________________ State: ______ Zip: ________
Telephone #: ____________________ (*day*) ____________________ (*evening*)
Date of Birth: ____________________ Sex: . Male . Female

Primary Care Physician: Name: ________________________________
Address: ________________________________
____

List all other Physicians that your records should be sent to:

Name	Address	Phone #	Fax #
____________	____________	________	________
____________	____________	________	________

Pain Related Information.

Please answer all questions.

1) Describe the event(s) surrounding the onset of your pain. (I.e. date of injury, is it the same or getting worse?).
____
____
____
____

2) Duration of Pain: Years _______ Months _______

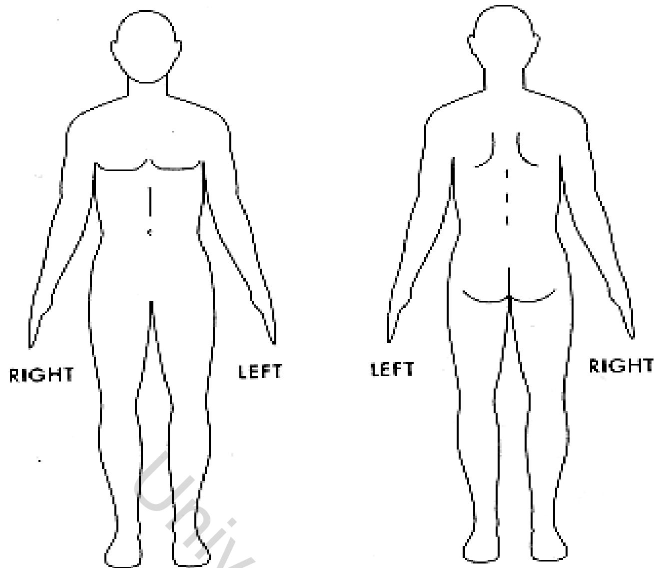
3) How many physicians have been involved in the treatment of your pain? (Please **circle**)
0-3 4-5 6-10 11-15 16-20

4) How many emergency room visits have you had in the last year for pain? (Please **circle**)
0 1 2 3 5 - 10

5) **Circle** all the things that make your pain ***worse***:
sitting standing rest heat cold walking exercise sex touch other

6) **Circle** all the things that make your pain ***better***:
sitting standing rest heat cold walking exercise sex touch other

7) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



8) I have some form of pain now that requires medication each and every day   Yes   No

9) Did you take pain medications in the last 7 days?   Yes   No

10) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, toothaches). Have you had pain other than these everyday kinds of pain during the last week? Yes   No   If YES, what kind?

11) Please rate your pain by **circling** the one number that best describes your pain at its **worst in the last week**.

0   1   2   3   4   5   6   7   8   9   10
No Pain   as bad as pain you can imagine

12) Please rate your pain by **circling** the one number that best describes your pain at **its least in the last week**.

0   1   2   3   4   5   6   7   8   9   10
No Pain   as bad as pain you can imagine

13) Please rate your pain by **circling** the one number that best describes **your pain on the average**.

0   1   2   3   4   5   6   7   8   9   10
No Pain   as bad as pain you can imagine

14) Please rate your pain by **circling** the one number that tells how much **pain you have right now**.

0   1   2   3   4   5   6   7   8   9   10
No Pain   as bad as pain you can imagine

15) What kinds of things make your pain feel **better** (for example, heat, medicine, rest)?

16) What kinds of things make your pain **worse** (for example, walking, standing, and lifting)?

17) In the last week, how much relief have pain treatments or medications provided? Please **circle** the one percentage that most shows how much relief you have received.

0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%
No Complete   Complete Relief

18) If you take pain medication, how many hours does it take before the pain returns?   **Circle appropriate response:**

Pain medication doesn't help at all
One hour
Two hours
Three hours
Four hours
Five to twelve hours
More than twelve hours
I do not take pain medication

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19) For each of the following words, circle **Yes** or **No** *if* that adjective applies to your pain

Aching	Yes	No
Throbbing	Yes	No
Shooting	Yes	No
Stabbing	Yes	No
Gnawing	Yes	No
Sharp	Yes	No
Tender	Yes	No
Burning	Yes	No
Exhausting	Yes	No
Tiring	Yes	No
Penetrating	Yes	No
Nagging	Yes	No
Numb	Yes	No
Miserable	Yes	No
Unbearable	Yes	No

20) **Circle** the one number that describes how, during the past week, pain has interfered with your:

A. General Activity

0 1 2 3 4 5 6 7 8 9 10
Does not interfere completely interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10
Does not interfere completely interferes

C. Walking Ability

0 1 2 3 4 5 6 7 8 9 10
Does not interfere completely interferes

D. *Normal Work* (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
Does not interfere completely interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10
Does not interfere completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not interfere completely interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
Does not interfere completely interferes

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21) I prefer to take pain medicine: (**circle** appropriate response)

On a regular basis   Only when necessary   Do not take pain medicine

22) Other methods I use to relieve my pain include: (Please check all that apply)

___ Warm compresses
___ Cold compresses
___ Relaxation techniques
___ Distraction
___ Biofeedback
___ Hypnosis
___ Other: ____

23) Check the nerve blocks, injections or procedures that have been performed.

Procedure	How many	Date Performed
___ Cervical (neck) Epidural Steroid Inj.	___________	______________________________
___ Lumbar Epidural Steroid Injection	___________	______________________________
___ Caudal Epidural Steroid Injection	___________	______________________________
___ Facet Joint Block	___________	______________________________
___ Facet Joint Denervation	___________	______________________________
___ Stellate Ganglion Block	___________	______________________________
___ Lumbar Sympathetic Block	___________	______________________________
___ Trigger point injection	___________	______________________________
___ Discogram	___________	______________________________
___ Occipital Nerve Block	___________	______________________________
___ Intercostal Nerve Block	___________	______________________________
___ Spinal cord stimulator	___________	______________________________
___ Intrathecal pump	___________	______________________________

24) Have you ever been discharged from another pain clinic for any reason? If yes, please explain:

____
____

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25) Have you ever had your medications lost or stolen?

26) Is anyone else in your household taking pain medications?

27) Medical History: (including high blood pressure, diabetes, cancer, seizure disorder, stroke, etc)
Please List: ____
____

28) Have you been hospitalized in the past? YES NO If yes, please explain:
____

29) Surgeries:
Have you had surgery in the past? YES NO
If yes, please list by date:

____
____

30) Are you currently or have you ever been treated for any psychiatric disorders? YES NO
If yes, who is your psychiatrist? ____

31) Which best describes your Childhood ***(circle one)***: Normal Chaotic

32) Have you ever been the victim of physical or sexual abuse? YES NO If yes, please explain on lines below:
____
____

33) Family's Medical History
Please list any major illnesses in your family. Including **cancer, stroke, high blood pressure, diabetes, chronic pain**, and others.
____
____
____

34) Medication Allergies:

Drug	Reaction
______________________________	______________________________
______________________________	______________________________

Are you allergic to iodine or contrast dye (for IVP, myelogram, etc.)? YES NO
If allergic, what happens?

____

35) Past Pain Medications: Have you ever taken any of the following pain-related medications? If so, please check the box next to the drug in the list below. Then note the dosage/frequency prescribed followed by the reason it was stopped .

Medication	Dose and Frequency	Stopped due to:
ACETAMINOPHEN (TYLENOL)		
IBUPROFEN (MOTRIN, ADVIL)		
TORADOL (KETOROLAC)		
CELEBREX		
ULTRAM (TRAMADOL)		
CODEINE (Tylenol #3)		
DEMEROL		
DILAUDID		
FENTANYL PATCH		
KADIAN		
AVINZA		
HYDROCODONE (VICODIN)		
METHADONE (DOLOPHINE)		
MORPHINE (MS CONTIN)		
OXYCONTIN		
OXYCODONE (PERCOCET)		
BUTORPHANOL (STADOL)		
PENTAZOCINE HCI (TALWIN)		
SUBOXONE		
SUBUTEX		
PROPOXYPHENE (DARVOCET)		
AMITRIPTYLINE (ELAVIL)		
IMIPRAMINE		
DESIPRAMINE		
DOXEPIN (SINEQUAN)		
NORTRIPTYLINE (PAMELOR)		
CYMBALTA		
EFFEXOR		
PRISTIQ		
PROZAC/PAXIL		
TRAZADONE (DESYREL)		
WELLBUTRIN		
LIDODERM PATCH		
NEURONTIN		
LYRICA		
DEPOKOTE		
TEGRETOL		
TOPAMAX		
LAMICTAL		
DEXTROMETHORPHAN		
VALIUM		
CLONAZEPAM		
BACLOFEN		
FLECTOR		
XANAX		
SKELAXIN		
ZANAFLEX		
SOMA		
Others not listed		

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36) Review of Systems: Please review the lists grouped below. If you have currently, or have had a *problem* in any of these areas, please circle **"yes"** and explain in the space next to your response. If not, please circle **"no"**.

General/ENT

Skin	NO	YES	______________________
Head	NO	YES	______________________
Eyes	NO	YES	______________________
Ears	NO	YES	______________________
Nose/Sinus	NO	YES	______________________

Lungs and Chest:

Asthma	NO	YES	______________________
Emphysema	NO	YES	______________________
Lung Cancer	NO	YES	______________________
Pneumonia	NO	YES	______________________

Heart and Blood Vessels:

Heart attack	NO	YES	______________________
Angina (chest pain)	NO	YES	______________________
High blood pressure	NO	YES	______________________
Irregular heartbeat	NO	YES	______________________
Poor circulation in legs	NO	YES	______________________
Blood clot in legs	NO	YES	______________________
Blood clot in lungs	NO	YES	______________________
Sores that won't heal	NO	YES	______________________
Swellings in legs	NO	YES	______________________

Urinary/Genital

Kidney stones	NO	YES	______________________
Painful urination	NO	YES	______________________
Urinary dribbling	NO	YES	______________________
Difficult urinating	NO	YES	______________________
Urinary infections	NO	YES	______________________
Incontinence	NO	YES	______________________

Bones/Joints

Broken bones	NO	YES	______________________
Arthritis	NO	YES	______________________
Amputations	NO	YES	______________________

Nerves/Brain

Sensation loss	NO	YES	______________________
Fainting	NO	YES	______________________
Seizures	NO	YES	______________________
Stroke	NO	YES	______________________
Spinal cord injury	NO	YES	______________________
Multiple sclerosis	NO	YES	______________________
Headache/Migraine	NO	YES	______________________
Coordination loss	NO	YES	______________________
Weakness/Paralysis	NO	YES	______________________
Disc problems	NO	YES	______________________

Blood

Anemia ("low blood")	NO	YES	______________________
Abnormal clotting	NO	YES	______________________
Easy bruising/bleeding	NO	YES	______________________
Transfusions	NO	YES	______________________

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Stomach/Esophagus/Intestines

Heartburn	NO	YES ______
Nausea/Vomiting	NO	YES ______
Constipation	NO	YES ______
Diarrhea	NO	YES ______
Hemorrhoids	NO	YES ______
Gallstones	NO	YES ______
Changes in stool	NO	YES ______
Hernia	NO	YES ______
Ulcers	NO	YES ______
Polyps	NO	YES ______

Psychology/Psychiatry

Depression	NO	YES ______
Anxiety	NO	YES ______
Panic attacks	NO	YES ______
Suicidal thoughts	NO	YES ______
Sleep disturbance	NO	YES ______
Irritability	NO	YES ______
Mood swings	NO	YES ______
History of drug or prescription overdose	NO	YES ______

Endocrine (many of these are manifestations of depression also)

Heat/Cold Intolerance	NO	YES ______
Weight Loss/Gain	NO	YES ______
Change in Appetite	NO	YES ______
Change in Sexual Desire	NO	YES ______
Erectile Dysfunction (*Male*)	NO	YES ______
Change in Menstrual Cycle *(Female)*	NO	YES ______

37) Please read each group of statements carefully. Check the box next to the ***one*** statement in each group which best describes the way you have been feeling **for the past week, including today.** Be sure to read all the statements in each group before making your choice.

A.
- ☐ I do not feel sad.
- ☐ I feel sad.
- ☐ I feel sad all the time and I can't snap out of it.
- ☐ I am so sad or unhappy that I can't stand it.

B.
- ☐ I am not particularly discouraged about the future.
- ☐ I feel discouraged about the future.
- ☐ I feel I have nothing to look forward to.
- ☐ I feel that the future is hopeless and that things cannot improve.

C.
- ☐ I do not feel like a failure.
- ☐ I feel that I have failed more than the average person.
- ☐ As I look back on my life, all I can see is a lot of failure.
- ☐ I feel I am a complete failure as a person.

D.
- ☐ I get as much satisfaction out of things as I used to.
- ☐ I don't enjoy things the way I used to.
- ☐ I don't get real satisfaction out of anything anymore.
- ☐ I am dissatisfied or bored with everything

E.
- ☐ I don't feel particularly guilty.
- ☐ I fell guilty a good part of the time.
- ☐ I feel guilty most of the time.
- ☐ I feel guilty all of the time.

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(#37: Statement Groups —continued)

F.
- ☐ I don't feel I am being punished.
- ☐ I feel I may be punished.
- ☐ I expect to be punished.
- ☐ I feel I am being punished.

G.
- ☐ I don't feel disappointed in myself.
- ☐ I am disappointed in myself.
- ☐ I am disgusted in myself.
- ☐ I hate myself.

H.
- ☐ I don't feel I am any worse than anybody else.
- ☐ I am critical of myself for my weaknesses or mistakes.
- ☐ I blame myself all the time for my faults.
- ☐ I blame myself for everything bad that happens.

I.
- ☐ I don't have any thoughts of killing myself.
- ☐ I have thought of killing myself, but I would not carry them out.
- ☐ I would like to kill myself.
- ☐ I would kill myself if I had the chance.

J.
- ☐ I don't cry anymore than usual.
- ☐ I cry more now than I used to.
- ☐ I cry all the time now.
- ☐ I used to be able to cry, but now I can't cry even though I want to.

K.
- ☐ I am no more irritated now than I ever am.
- ☐ I get annoyed or irritated more easily now than I used to.
- ☐ I feel irritated all the time now.
- ☐ I don't get irritated at all by things that used to irritate me.

L.
- ☐ I have not lost interest in other people.
- ☐ I am less interested in people than I used to be.
- ☐ I have lost most of my interest in other people.
- ☐ I have lost all my interest in other people.

M.
- ☐ I make decisions about as well as I ever could.
- ☐ I put off making decisions more than I used to.
- ☐ I have greater difficulty in making decisions than before.
- ☐ I can't make decisions at all anymore.

N.
- ☐ I don't feel I look any worse than I used to.
- ☐ I am worried that I am looking old or unattractive.
- ☐ I feel that there are permanent changes in my appearance that make me look unattractive.
- ☐ I believe that I look ugly.

O.
- ☐ I work about as well as before.
- ☐ It takes an extra effort to get started at doing something.
- ☐ I have to push myself very hard to do anything.
- ☐ I can't do any work at all.

P.
- ☐ I can sleep as well as usual.
- ☐ I don't sleep as well as I used to.
- ☐ I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
- ☐ I wake up several hours earlier than I used to and cannot get back to sleep.

Q.
- ☐ I don't get tired more than I used to.
- ☐ I get tired more easily than I used to.
- ☐ I get tired from doing almost anything.
- ☐ I am too tired to do anything.

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38) WORK:
Do you work? Yes No
If yes, what do you do? ________________________________ How many hours per day ________________
If no, how long have you been out of work? _________ *What was your occupation?* ________________________
If you do not work, how do you spend your day? ____
Have you ever been in the military? Yes No
Are you able to do household chores? Yes No (explain) ____________________________________

39) INCOME:
Are you on *Disability*? Yes No
Are you involved with *Worker's Compensation*? Yes No
Is there any *litigation* pending against an employer or individual involved in an accident or injury? Yes No
Are you *applying* for disability or worker's compensation? If so, which one? ______________________________
Are you having trouble keeping up with bills? (stress inc pain, medication choices etc)

40) HOUSEHOLD:
What are your hobbies? ____
Circle your present marital status? Single Married Separated Divorce Widowed
If you have children, how many and how old? ____

41) DAILY ACTIVITIES:
What exercises do you participate in? ____
Circle the number between 0 and 10 which represents your activity level.
(inactive) 0 1 2 3 4 5 6 7 8 9 10 (Very active)

42) SEXUAL ACTIVITIES:
Circle the number between 0 and 10 which represents your present satisfaction regarding your sexual activity.
(Greatly unsatisfied) 0 1 2 3 4 5 6 7 8 9 10 (Greatly satisfied)

"Does spirituality or religion play an important role in your life?"
YES ________________ NO
Circle the number between 0 and 10, which represents your involvement in religious activities (i.e. church, synagogue, mosque)
(no involvement) 0 1 2 3 4 5 6 7 8 9 10 (Actively involved)

43) EDUCATION:
Have you completed? (circle) Grade School High School Junior College College
Trade School Graduate School Professional School

44) SOCIAL:
Circle the number between 0 and 10 which represents your involvement in social activities
(no involvement) 0 1 2 3 4 5 6 7 8 9 10 (Actively involved)
Is this a change since the onset of your pain? YES NO
Do you smoke? YES NO If yes, how many packs per day? _________ How many years? ______________
Do you use alcohol? YES NO About how often? ____
Was there ever a time in your life when you had an alcohol or drug problem? YES NO
Did you or do you use *street drugs*? YES NO If yes, which ones ______________________________
Have you ever been *addicted* to or had difficulty controlling the use of prescription drugs? YES NO
Does anybody in your family have a history of drug or alcohol misuse/abuse/addiction? YES NO
Has anybody ever expressed concern about your overuse of drugs or alcohol? YES NO
Have you ever been in a **treatment program** for *alcohol* or *drug abuse*? YES NO
If YES, please explain ____
Have you ever attended a 12 step meeting such as AA or NA? YES NO
Have you ever had a DUI or been arrested for illicit drug use? YES NO
Have you ever been arrested for selling drugs? YES NO
Have you ever had a drug overdose? YES NO
Does anyone else in your household use pain medications? YES NO
Does anyone else in your household use illicit drugs? YES NO
Have you ever had problems with gambling? YES NO
Have you ever had an eating disorder such as bulimia, or anorexia? YES NO
Have you ever had a gastric bypass or gastric banding? YES NO

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(#44: SOCIAL—continued)

Current Opioid Therapy, if applicable (for example, percocet, oxycontin, duragesic patch):

What percent of relief do your opioids (*narcotics*) provide? ______________________%

Do you have any side effects from your opioids? (*Place a check by any of the following side effects that apply*):

☐ no side effects	☐ constipation	☐ itching	☐ dry mouth	☐ nausea
☐ erectile problems	☐ menstrual change	☐ vomiting	☐ dizziness	☐ sleepiness
☐ lightheadedness	☐ problems urinating	☐ appetite change	☐ tooth decay.	

Are you any more functional from using opioids? *(circle)* No Yes If so, how?

____

Are your opioids kept in a secure place? (*circle*) No Yes Where?_______________________________

Do you feel that your mood has improved from opioid therapy? (*circle)* No Yes If so, how?

____

Has your quality of life improved? *(circle)* No Yes If so, how?_______________________________

Name of pharmacy listed on opioid bottle? ____

45) EXPECTATIONS:

What are you hoping to gain from your visit with the University of Florida Pain Institute?

Consider: List tangible three activities or goals that adequate pain control would allow you to participate in or achieve

____

____

____

46) Circle the percentage of pain relief you would feel would make your treatment worthwhile.

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

47) Please now fill out your "CURRENT MEDICATION LIST".

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (PRESCRIPTION, OVER THE COUNTER AND HERBAL).

____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

THANK YOU FOR COMPLETING THIS FORM.

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