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 completed 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.

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.

Right Left Left Right

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	Four hours
One hour	Five to twelve hours
Two hours	More than twelve hours
Three hours	I do not take pain medications

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

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.

	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:

____

____

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 ____________________ ______________________________

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 ____

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) 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)__________________________________

38) 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)

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

40) DAILY ACTIVITIES:
What exercises do you participate in? ____
Circle the number between 0 and 10 which represents your activity level.

0 1 2 3 4 5 6 7 8 9 10
(inactive) (Very active)

41) SEXUAL ACTIVITIES:
Circle the number between 0 and 10 which represents your present satisfaction regarding your sexual activity.

0 1 2 3 4 5 6 7 8 9 10
(Greatly unsatisfied) (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 (church, synagogue, mosque)
0 1 2 3 4 5 6 7 8 9 10
(no involvement) (Actively involved)

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

43) SOCIAL:
Circle the number between 0 and 10 which represents your involvement in social activities
0 1 2 3 4 5 6 7 8 9 10
(no involvement) (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

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
lighthеadedness	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?____

44) 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

____
____
____

45) Circle the percentage of pain relief you would feel would make your treatment worthwhile.
10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

46) 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.