PCA
PAIN CARE CENTER

HEALTH HISTORY QUESTIONNAIRE

Date: _____

First Name: _____ Middle: _____ Last: _____

SSN: ____-_____-_____ Date of Birth: _____/_____/_____ Gender: □ Male □ Female

Phone: (H) _____ (W) _____ (C) _____

Race: _____ Emergency Contact Person: _____ Number: _____

Physical Address:_____

City:_____State:_____Zip:_____

Mailing Address:_____

City:_____State:_____Zip:_____

Employer :_____Employee Phone:_____

Referring Provider: _____Primary Care Physician:_____

Insurance Carrier:_____ Insurance ID#_____

Group #_____ Subscribers Name: _____

Subscribers Date of Birth: _____ Relationship: _____

Insurance Address: _____

Is this a work related Injury?_____ If yes, please list the date of injury:_____

Financial Responsibility

Payment Policy: If you would like us to bill your insurance we will be happy to do so. Please note that if we are not contracted with your insurance company, it may be their policy to reimburse non-contracted providers. The ultimate responsibility for payment of your account remains solely with you, the patient. Your signature below gives us permission to contact your insurance carrier or other health care professionals treating you for assistance in billing only.
Cancellation Policy: We want you to keep your appointments because we believe it is in your best interest to receive this level of care. We require a 24-hour notice if you will be unable to keep your appointment. If you do not cancel your appointment within 24 hours you will be charged $25.00

I have read and understand my financial responsibilities

Patient Signature_____ Date: _____

Witness Signature_____ Date: _____

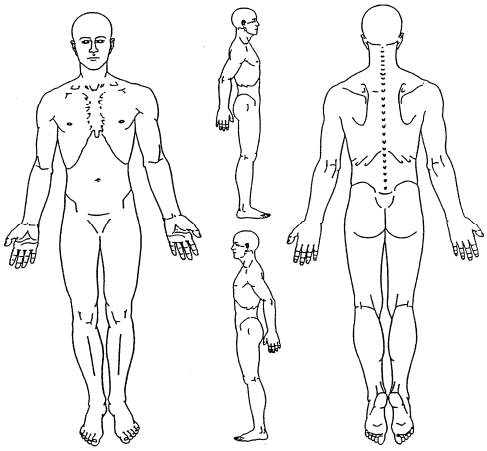
Chief Complaint and Present Illness

Reason for Visit: _____

Date or Time Since Symptoms Began: _____
Onset manner of symptoms: ☐Gradual ☐Sudden ☐Injury ☐ Variable

Frequency of Symptoms: _____
☐Rare ☐Occasional ☐Intermittent ☐Frequent ☐Constant

Location of Symptoms: _____
Please mark all areas of symptoms on the diagram



How have symptoms progressed: ☐Improved ☐Unchanged
☐Getting Worse

If symptoms include Pain, check the boxes that best describe:
☐Aching ☐Burning ☐Cramping ☐Crushing ☐Constricting
☐Deep ☐Dull ☐Gnawing ☐Heavy ☐Knife Like ☐Piercing
☐Pounding ☐Pressure Like ☐Sharp ☐Shooting ☐Stabbing
☐Tearing ☐Tender ☐Throbbing ☐Tight ☐Other _____

Severity of Pain: Rate your pain on a scale of 1-10 with 10 being the worst pain for each area. Mark on the diagram provided.

How long do your symptoms usually last:_____

How did symptoms start: _____

What brings on symptoms: _____ What makes symptoms worse: _____

What relieves symptoms: _____

Medications

Please list all medications that you are currently taking, **both prescription and over the counter**

Medication Name	Dosage	Frequency	Who Prescribed Medication

Allergies

List all allergies including medications and the reaction. If none, write none.

List Allergies	Reaction you had

Past Medical History

Please provide a list and history of all past medical conditions: Ex; Asthma, Diabetes, High blood pressure etc

_____

_____

Provide a complete list of all illnesses, injuries, surgeries, and hospitalization. (Use back of page if necessary)

List Illnesses, Surgeries, and Hospitalizations	Date	Treatment

Check any childhood diseases that you have had:
☐Chicken Pox ☐Measles ☐Mumps ☐Polio ☐Rheumatic Fever ☐Rubella ☐Scarlet Fever ☐None

Have you ever had a Blood Transfusion: ☐Yes ☐No
Have you ever been exposed to a Sexually Transmitted Disease: ☐Yes ☐No If yes, list disease: _____

Family History

	Status	Age	Illnesses	Cause of Death
Father	☐Living ☐Deceased ☐Unknown			
Mother	☐Living ☐Deceased ☐Unknown			

	Number	List any illnesses
Siblings		
Children		

Social History

Marital Status: ☐Single ☐Engaged ☐Married ☐Separated ☐Divorced ☐Spouse Deceased

Occupation: _____ Highest Level of Education: _____

Tobacco Use: ☐Never ☐Current ☐Discontinued - Type: _____ Quantity: _____ Years: ___
Alcohol Use: ☐Never ☐Beer(s) ___/Week ☐Liquor __/Week ☐Wine__/Week ☐Recovering Alcoholic

Caffeine: ___ Coffee ___ Tea ___Soda
Exercise: ☐Not Exercising ☐Exercising ___ Times per week - Type of exercise: _____

Illicit Drug Usage: ☐Never ☐Past History ☐Current. Please list drugs used _____
Drug/Alcohol Abuse Treatment ☐Yes ☐ No: If yes, ☐ In-Patient ☐ Out-Patient ☐ Both

Review of Systems

Please check all symptoms or illnesses that you have **currently**.

General
- ☐ Anorexia
- ☐ Appetite Loss
- ☐ Chills
- ☐ Dietary Changes
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweating
- ☐ Persistent Infections
- ☐ Weight Change
- ☐ None of above

Skin
- ☐ Brittle Nails
- ☐ Bruising
- ☐ Change in Wart/Mole
- ☐ Clamminess
- ☐ Cracked Lips
- ☐ Dryness
- ☐ Excessive Sweating
- ☐ Hair Loss
- ☐ Hives
- ☐ Itching
- ☐ Nail Changes
- ☐ New Lesions
- ☐ Pale Skin
- ☐ Rash
- ☐ Skin Color Changes
- ☐ Ulcers
- ☐ None of above

HEENT
- ☐ Headache
- ☐ Head Injury
- ☐ Blurred Vision
- ☐ Blindness
- ☐ Color Blindness
- ☐ Decrease Vision
- ☐ Double Vision
- ☐ Excessive Tearing
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Glaucoma
- ☐ Puffiness
- ☐ Visual Disturbances
- ☐ Vision Loss
- ☐ Glasses/Contacts
- ☐ Hearing Loss
- ☐ Deafness
- ☐ Ear Discharge
- ☐ Ear Infection
- ☐ Ear Pain
- ☐ Ringing in Ears
- ☐ Spinning Sensation
- ☐ Vertigo
- ☐ Runny Nose
- ☐ Nose Bleeds
- ☐ Frequent Colds
- ☐ Nasal Congestion
- ☐ Sneezing
- ☐ Sleep Apnea
- ☐ Seasonal Allergies
- ☐ Runny Nose
- ☐ Sinus Pain
- ☐ Snoring
- ☐ Bleeding Gums
- ☐ Hoarseness
- ☐ Trouble Smelling
- ☐ Mouth Ulcers
- ☐ Sore Throat
- ☐ Voice Changes
- ☐ Face Numbness/Tingle
- ☐ None of above

Neck
- ☐ Neck Mass
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Neck Swelling
- ☐ Swollen Glands
- ☐ None of Above

Lungs/Respiratory
- ☐ Bloody Sputum
- ☐ Chronic Coughing
- ☐ Cough
- ☐ Decreased Exercise Tolerance
- ☐ Shortness of Breath
- ☐ Shortness of Breath with Exertion
- ☐ Difficulty Breathing
- ☐ Coughing Blood
- ☐ Sputum Production
- ☐ Wheezes
- ☐ None of above

Breast
- ☐ Breast Mass
- ☐ Breast Pain
- ☐ Breast Swelling
- ☐ Gynecomastia
- ☐ Nipple Discharge
- ☐ Nipple Pain
- ☐ Recent Breast Size Changes
- ☐ Breast Skin Changes
- ☐ None of above

Heart/Cardiac
- ☐ Abnormal Blood Pressure
- ☐ Bradycardia
- ☐ Calf Cramps
- ☐ Chest Pain
- ☐ Claudication
- ☐ Difficulty Breathing Lying Down
- ☐ Edema
- ☐ Hypertension
- ☐ Fainting
- ☐ Heart Stent
- ☐ Irregular Heart Beat
- ☐ Leg Cramps
- ☐ Leg Pain/Swelling
- ☐ Night Cramps
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Rapid Heart Rate
- ☐ Slow Heart Rate
- ☐ Swelling of Extremities
- ☐ None of above

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Abdominal Swelling
- ☐ Belching
- ☐ Black Tarry Stool
- ☐ Bloating
- ☐ Bloody Stool
- ☐ Changes in Bowels
- ☐ Choking
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Difficulty Tasting
- ☐ Excessive Gas
- ☐ Food Intolerance
- ☐ Gas
- ☐ Hemorrhoids

Review of Systems Continued

Please check all symptoms or illnesses that you have **currently**.

☐ Heartburn
☐ Indigestion
☐ Nausea
☐ Pain With Bowel Movements
☐ Rectal Bleeding
☐ Vomiting
☐ None of above

Male Only

☐ Blood in Urine
☐ Change in Bladder Habits
☐ Change in Urinary Stream
☐ Difficulty with Erection
☐ Discharge
☐ Painful Urination
☐ Flank Pain
☐ Hesitancy
☐ Impotence
☐ Penile Lesions
☐ Testicular Mass
☐ Testicular Pain
☐ Urinary Urgency
☐ None of above

Endocrine

☐ Cold Intolerance
☐ Decreased Sweating
☐ Excessive Sweating
☐ Excessive Urination
☐ Hair Changes Heat Intolerance
☐ Hot Flashes
☐ Libido Change
☐ Thyroid Problems
☐ None of above

Female Only

☐ Absence of Menstruation
☐ Blood in Urine
☐ Changes in Bladder Habits
☐ Changes in Urinary Stream
☐ Difficulty Emptying Bladder
☐ Discharge
☐ Excessive Menstrual Bleeding
☐ Incontinence
☐ Menstrual Irregularities
☐ Painful Intercourse
☐ Painful Urination
☐ Pelvic Pain
☐ Urgency
☐ Urinary Complaints
☐ Vaginal Bleeding
☐ Vaginal Discharge
☐ Vaginal Dryness
☐ Vaginal Fluid
☐ None of above

Date of last Menstrual Period: _____

Musculoskeletal

☐ Back Pain
☐ Backache
☐ Calf Pain
☐ Decrease Range of Motion
☐ Joint Pain
☐ Joint Redness
☐ Joint Stiffness
☐ Joint Swelling
☐ Leg Cramps
☐ Muscle Atrophy
☐ Muscle Cramps
☐ Muscle Weakness
☐ Neck Pain
☐ Physical Disability
☐ Swelling of Extremities
☐ None of above

Psychiatric

☐ Anxiety
☐ Change in Sleep Pattern
☐ Delirium
☐ Delusions
☐ Depression
☐ Disorientation
☐ Easily Irritated
☐ Fearful
☐ Frequent Crying
☐ Hallucinations
☐ Can't Concentrate
☐ Insomnia
☐ Memory Loss
☐ Mood Changes
☐ Nervousness
☐ Panic Attacks
☐ Suicidal Ideation
☐ Suicidal Planning
☐ None of above

Neurological

☐ Attention Deficit
☐ Decrease Memory
☐ Confusion
☐ Dizziness
☐ Easily Distracted
☐ Fainting
☐ Hyperactivity
☐ Loss of Coordination
☐ Loss of Consciousness
☐ Numbness
☐ Personality Changes
☐ Pins and Needles
☐ Seizures
☐ Poor Balance
☐ Pinning Sensation
☐ Stroke
☐ Speech Difficulty
☐ Tremor
☐ Unsteadiness
☐ Sudden Jerks
☐ Weakness in Extremities
☐ None of above

Blood/Lymphatics

☐ Abnormal Bleeding
☐ Anemia
☐ Blood Clots
☐ Easy Bruising
☐ Enlarged Lymph nodes
☐ Prolonged Bleeding
☐ Spontaneous Bleeding
☐ None of above

By signing below I certify that that above information is true to the best of my knowledge and I consent for the provider to evaluate, recommend and treatment me for the condition or conditions present above.

_____ _____

Signature Date