Community HOSPITAL

INTERVENTIONAL PAIN MANAGEMENT PATIENT QUESTIONNAIRE

Revised: 8/8/16

Exam Date:_____
Status:
DOB: Age:

Name:_____

Ref Phys:
Att Phys:
Prim Care Phys:
Register/Admit Date:

(Place Pre-Printed Patient Data Label Here)

BRIEFLY DESCRIBE YOUR PRIMARY PAIN COMPLAINT:_____

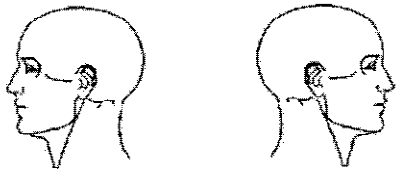
_____

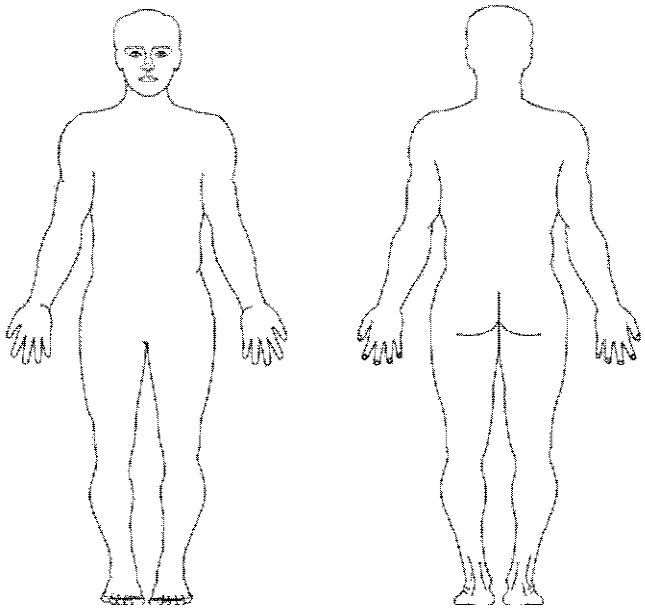
HOW LONG HAVE YOU HAD THIS PAIN?_____

WHERE IS YOUR PAIN?

Using the symbols listed below, mark on the drawing the areas where you feel your pain.

SYMBOLS:
NNN - Numbness
PPP - Pins & Needles
BBB - Burning
SSS - Stabbing
AAA - Aching





PAIN CAUSED BY:

- ☐ No specific event
- ☐ Work injury
- ☐ Car accident
- ☐ Surgery
- ☐ Other cause: _____

PAIN PATTERN:

- ☐ Continuous
- ☐ Comes & Goes
- ☐ Brief/Momentary

PAIN RADIATES TO MY: (choose all that apply)

☐ Head	☐ Arm	☐ Back
☐ Neck	☐ Chest	☐ Hip
☐ Shoulder	☐ Abdomen	☐ Leg

MEDICAL BACKGROUND:

Do you have an allergy to iodine or x-ray contrast? ☐ Yes ☐ No

Please list any medication allergies:_____

Are you pregnant or could you be pregnant? ☐ Yes ☐ No

Do you take blood thinners? (Coumadin, warfarin, Plavix, heparin)? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No How often do you drink alcohol?_____drinks per week

Major Medical Problems:

_____

_____

_____

Previous Surgeries:

_____

_____

_____