Patient Name:

Tallahassee Pain Management Plus

Date:

Height \_

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Yes

No

No

No

No

No

No

No

No
No

No

Yes No

No

Yes

Yes

Yes

Yes

Yes

No

No

No

No

No

 Weight-: \_

Problems with Anesthesia?

Diabetes? Controlled with (circle): Insulin Pills

Diet

Heart Problems? Circle the one that applies:

Heart attack (year) ; Coronary heart disease;

PacemakerlDefibrillator; Irregular heart beat; Palpitations;
Other-

----

High Blood Pressure?

Breathing Problems? (circle) On oxygen; Asthma; COPD;
Emphysema; Chronic Cough; Sleep Apnea; Bronchitis;

Other \_

Smoker? \_\_ packs per day

Stomach or Digestion problems? GERD! Reflux

Stroke: year of stroke.

Weakness-where.

---

Seizures?

How often?

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Kidney/ Urinary Problems? Describe:

Liver/ Thyroid Problems? Describe:

Blood Thinners?( circle) Coumadin Pradaxa Warfrin Plavix

Aspirin 81mg/ 325mg Fish Oil Vitamin E Other \_

Do you have Cancer? Where?

Undergoing treatment now? \_

When?

-----

Arthritis?

Psychiatric Problems?
Substance Abuse?

Drink Alcohol? \_ drinks per day

\_perweek

Tallahassee Pain Management Plus

I

To help us meet all of your healthcare needs, please answer the following questions

as completely as possible. Thank you.

PATIENT INFORMATION:

 DATE: \_

SEX: M F AGE: \_

NAME:

SSN:

 BIRTHDATE: MARITAL STATUS:

ADDRESS: CITY! STATE: ZIP: \_

HOME #: CELL #: WORK #: \_

E-NUULADDRESS: \_

DO YOU HAVE A LIVING WILL ON FILE: YES OR

NO

PRIMARY DR: SOURCE OF REFERRAL:

ARE YOU PRESENTLY: EMPLOYED *I* RETIRED *I* DISABLED *I* UNEMPLOYED

WHA TW ASORISYOUROCCUPA nON?

IS THEIR A LAWYER INVOLVED WITH YOUR INJURY?
NAME OFLA WYER:

PERSON TO CONTACT IN CASE OF EMERGENCY:

 PHONE#: \_

RELATION:

PHARMACY NAME:

PHARMACYPHONE#: \_

LOCATION:

SELFPAY: \_

DATE

PATIENT SIGNATURE:

DATE: