Hess Orthopedics – Pain Management
New Patient Questionnaire

Welcome to Hess Orthopedics Pain Management Clinic! Please complete this form as it helps us best treat your pain. Please answer every question the best you can. We use ALL of the answers to these questions to tailor treatment to your specific condition. **Also, please bring your medications (or a list of them with name and dosing instructions) and any imaging records (printed reports and images on CD) to your appointment.** Thank you for helping us to help you!

Contact Information

Full Name: _____

Date of Birth: _____

Mailing Address: _____

_____

Phone Number: (_____)_____

Is it okay for us to leave a voicemail or message with laboratory or imaging results? YES NO

Emergency Contact: _____

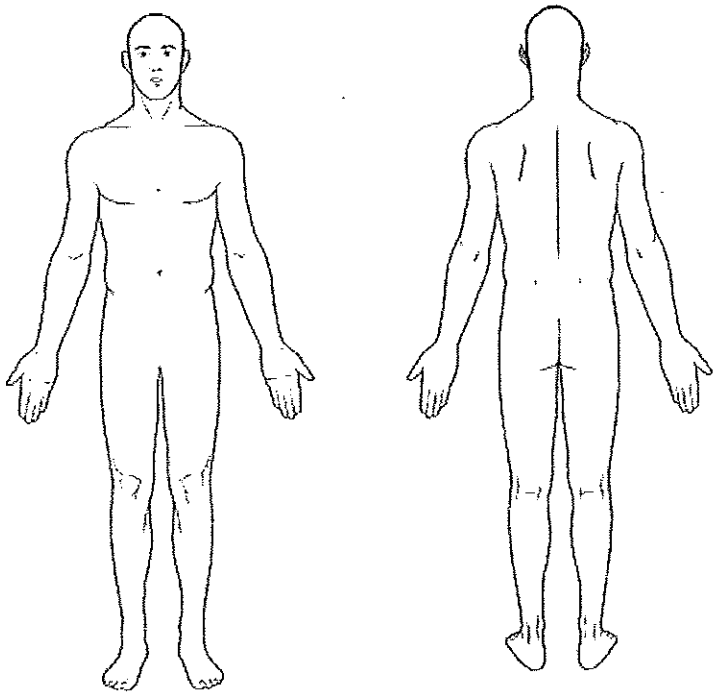
Emergency Contact Phone Number: (_____)_____

Is it okay for us to share health information (such as laboratory or imaging results) with your emergency contact? YES NO

Preferred Pharmacy: _____

Tell Us About Your Pain

Where is most of your pain? Please draw on diagram to the right:



What is your average pain score today? Please circle a number below.

0 1 2 3 4 5 6 7 8 9 10
No pain Severe pain

When did your pain start? Be as specific as possible. _____

Did you have a specific injury that caused your pain? If so, please describe what happened.

_____

_____

How would you describe your pain? Please circle all that apply.

Sharp Aching Cramping Dull Burning Shooting Other:_____

What makes your pain worse? _____

What makes your pain better? _____

Functionally, what does your pain limit you the most from doing? _____

Please tell us if you have any other symptoms. Please circle YES or NO.

Fever	YES	NO
Blurry vision	YES	NO
Hearing loss	YES	NO
Chest pain	YES	NO
Shortness of breath	YES	NO
Nausea or vomiting	YES	NO
Constipation	YES	NO
Excessive thirst	YES	NO
Bladder incontinence	YES	NO
Bowel incontinence	YES	NO
Weakness (in arms or legs)	YES	NO
Anxiety	YES	NO
Depression	YES	NO
Rash	YES	NO
Easy bleeding or bruising	YES	NO
Allergic reaction	YES	NO

What laboratory tests (i.e. blood work), imaging (i.e. CT, MRI, ultrasound), or other studies (i.e. EMG) have you had for your pain?

Test (i.e. MRI, CT)	Year	Location of Test (i.e. name of hospital or clinic performed)

What medications (including over-the-counter medications, vitamins, herbs) are you taking **for pain?**

_____

_____

What medications (including over-the-counter medications, vitamins, herbs) have you tried **for pain**?

_____

_____

What injections have you had **for you pain**?

_____

_____

What surgeries have you had **for your pain?**

_____

_____

What else has been done to treat your pain?

_____

_____

Is there any pending litigation regarding your condition? YES NO

Is there still a pending disability claim for your condition? YES NO

Is there still a pending worker's compensation claim for your condition? YES NO

Please list all medical problems/diagnoses and the year you were diagnosed (including mental health diagnoses).

Diagnosis	Year Diagnosed

Please list all surgical procedures you have had and the year it was performed.

Surgery (including side, if applicable)	Year Performed

Please list ALL current medications, dose and frequency.

Medication	Dose	Frequency (i.e. 3 times per day)

Please list ALL medications that you are allergic to:

Medication	Type of Reaction (i.e. anaphylaxis, rash)

Are you pregnant? YES NO

Do you use tobacco products (i.e. smoke cigarettes/cigars, chew tobacco)? YES NO
How much? _____ per day

Do you drink alcohol? YES NO
Frequency? _____

Do you use any other drugs (illegal or legal)? YES NO
If so, what drugs? _____

Have you ever been diagnosed with or had treatment for alcohol abuse? YES NO

Has anyone in your family ever been diagnosed with or had treatment for alcohol abuse? YES NO

Have you ever been diagnosed with or had treatment for illegal drug use? YES NO

Has anyone in your family ever been diagnosed with or had treatment for illegal drug use? YES NO

Have you ever been diagnosed with or had treatment for abuse of prescription medications? YES NO

Has anyone in your family ever been diagnosed with or had treatment for abuse of prescription medications? YES NO