Kansas Center for Pain Relief

HEALTH QUESTIONNAIRE

PATIENT NAME:	DOB:	TODAYS DATE:

MEDICATIONS: List all Medications you are currently taking (include over the counter medications) if you need more space use back of this form.		
ALLERGIES: List all allergies to Medications, foods, and environmental factors. Write **"NONE"** if no known allergies.		
Latex: Yes No		

MEDICAL HISTORY: Do you have or had any of the following?

	AIDS/HIV		Glaucoma		Liver disease		Stroke
	Anemia		Heart Disease		Lupus		Thyroid disease
	Arthritis		Heart murmur		Migraine		Tuberculosis
	Cancer Type: _______		Hepatitis		Multiple Sclerosis (MS)		Other:
	Chronic pain		Herpes/Shingles		Myocardial Infarction		
	Colitis		High blood pressure		Osteoporosis		
	COPD		High Cholesterol		Pneumonia		
	Diabetes Type 1		Kidney disease		Seizures		
	Diabetes Type 2		Kidney stones		STD Type: _______		

SURGERIES/HOSPITALIZATIONS: List all and include date if known.

FAMILY HISTORY: If any "blood" relative(s) have suffered any of the following please match the **NUMBER** with corresponding relative.

Father:				
Mother:	1. Alcoholism	5. High Cholesterol	9. Heart disease	13. Osteoporosis
	2. Asthma	6. Diabetes Type: __	10. Hepatitis	14. Stroke
	3. Arthritis	7. Epilepsy	11.Hypertension	15. Thyroid Disease
	4. Cancer	8. Glaucoma	12. Mental Illness	

SOCIAL/LIFESTYLE HISTORY:

Smoking: Yes No — If yes: Current smoker or former smoker

Alcohol: Yes No — Drinks per week: ________

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	SYMPTOMS: Please mark all that apply						
	EYE/EAR/NOSE/THROAT		**CARDIOVASCULAR**		**GENITOURINARY**		**NEUROLOGICAL**
	Blocked ear		Chest pain		Blood in urine		Difficulty balancing
	Decreased hearing		Dizziness		Difficulty urinating		Headaches
	Difficulty swallowing		Irregular pulse		Frequent urination		Memory loss
	Dry mouth		Palpitations		Painful urination		Tingling/Numbness
	Ear pain		Weakness		**MUSCULOSKELTAL**		Tremor
	Ringing in the ears		Weight gain		Carpal tunnel		**PSYCHIATRIC**
	Sinus pain		**GASTROINTESTIONAL**		Joint stiffness		Anxiety
	Sore throat		Abdominal pain		Leg cramps		Depressed mood
	Swollen glands		Constipation		Pain in shoulders		Difficulty sleeping
	RESIPRATORY		Decreased appetite		Painful joints		Loss of appetite
	Chest pain		Diarrhea		Swollen joints		Suicidal
	Cough		Nausea		**SKIN**		
	Shortness of breath		Vomiting		Hives		
	Wheezing		Weight loss		Rash		