Valley Medical Group
Valley Health System

Today's Date: _____

PATIENT VISIT/MEDICAL HISTORY – PAIN MANAGEMENT

Patient Name: _____ Date of Birth: _____

ALLERGIES/ADVERSE REACTIONS

Medications	**Reaction**	**Food/Other** (please list)	**Reaction**
☐ Aspirin		☐ Sulfa:	
☐ IV Dye		☐ Other:	
☐ Latex		☐ Other:	
☐ Penicillin		☐ Other:	
☐ Shellfish		☐ Other:	

CURRENT MEDICATIONS (Please list all Prescription Drugs, Over-the-Counter Medications, Herbs and Vitamins that you are currently taking)

Name of Medication/Herb/Vitamin	**Dosage** (mg/ml)	**Frequency**

CHIEF COMPLAINT TODAY (Please check the reason for your visit today)

☐ Abdominal Pain	☐ Fibromyalgia	☐ Nerve Pain
☐ Acupuncture	☐ Leg Pain	☐ Shoulder Pain
☐ Back Pain	☐ Knee Pain	☐ Other:
☐ Cancer Pain	☐ Muscle Pain	☐ Other:
☐ CRPS	☐ Neck Pain	☐ Other:

PAST MEDICAL HISTORY (Please check those items that apply)

☐ ADD or ADHD	☐ COPD	☐ Lymphoma
☐ Allergies	☐ CVA- Cerebrovascular Accident	☐ Myocardial Infarction
☐ Alzheimer's Disease	☐ Deep Vein Thrombosis	☐ Narcolepsy
☐ Anemia	☐ Dementia	☐ Neurologic Disorder
☐ Anxiety Disorder	☐ Depression	☐ Obesity, Morbid
☐ Aortic Aneurysm	☐ Diabetes	☐ Osteoarthritis
☐ Arrhythmia	☐ Diverticulitis	☐ Osteoporosis
☐ Arthritis	☐ Eczema, Hives or other skin conditions	☐ Ovarian Cyst Uterine Fibroids PID
☐ Asthma	☐ ED- Erectile Dysfunction	☐ Pacemaker
☐ Atrial Fibrillation	☐ Endometriosis	☐ Parkinsonism
☐ Bipolar	☐ Fibromyalgia	☐ Peptic Ulcer
☐ Blood Clot	☐ GERD/Reflux	☐ Peripheral Arterial Disease
☐ BPH- Benign Prostatic Hyperplasia	☐ Glaucoma	☐ Psychiatric Problems/Illness
☐ Breast Cancer	☐ Gout	☐ PTCA with stent CABG

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PAST MEDICAL HISTORY *cont.* (Please check those items that apply)

☐ Cancer, Brain	☐ Headaches or Migraines	☐ Pulmonary Embolism
☐ Cancer, Lung	☐ Hypertension	☐ Restless Leg Syndrome Snoring
☐ Cancer, Cervical	☐ Heart Disease	☐ Pyelonephritis
☐ Cancer, Colon	☐ Hepatitis	☐ Raynaud's Syndrome
☐ Cancer, Esophagus	☐ High Cholesterol	☐ Renal Stones
☐ Cancer, Ovarian	☐ Hypothyroidism	☐ Rheumatoid Arthritis
☐ Cancer, Prostate	☐ IBS	☐ Seizures/Epilepsy
☐ Cancer, Skin, Melanoma	☐ Inflammatory Bowel Disorder	☐ Sleep Apnea
☐ Cancer, Uterine	☐ Insomnia	☐ Sleep Disorder
☐ Cardiomyopathy	☐ Kidney Disease	☐ Stroke
☐ Carotid Disease	☐ Kidney Stones	☐ Thyroid Disease
☐ Chronic Fatigue Syndrome	☐ Liver Disease	☐ TIA
☐ Congestive Heart Failure (CHF)	☐ Lupus-Systemic Lupus Erythematosis	☐ Valvular Heart Disease
☐ Other:	☐ Other:	☐ Other:
☐ Other:	☐ Other:	☐ Other:

SURGICAL HISTORY (Please check previous surgeries that you have had, including date)

Procedure	Date of Surgery	Procedure	Date of Surgery
☐ Abdominal Surgery		☐ Hydrocele Repair	
☐ Adenoid Surgery		☐ Hysterectomy	
☐ AICD		☐ Hysteroscopy	
☐ Amputation		☐ Joint Replacement	
☐ Angioplasty		☐ Knee Surgery	
☐ Appendectomy		☐ Laparoscopy	
☐ Arthroscopic Surgery		☐ Laparotomy	
☐ Back Surgery		☐ Lumpectomy	
☐ Breast Biopsy		☐ Mastectomy	
☐ Breast Implants		☐ Myomectomy	
☐ Breast Surgery		☐ Oophorectomy	
☐ Bronchoscopy		☐ Orthopedic Surgery	
☐ CABG		☐ Ovarian Cystectomy	
☐ Caesarean Section		☐ Neck Surgery	
☐ Cancer Surgery		☐ Pacemaker	
☐ Cardiac Catheterization		☐ Prostate Surgery	
☐ Cardiac Surgery		☐ Reconstructive Surgery	
☐ Cardioversion		☐ Splenectomy	
☐ Carotid Endarterectomy		☐ Stent	
☐ Cataract Surgery		☐ Thyroid Surgery	
☐ Cholecystectomy		☐ Tonsillectomy	
☐ Coronary Artery Stent		☐ Tonsillectomy Adenoidectomy	
☐ Dilation and Curettage		☐ Total Abdominal Hysterectomy	
☐ Ectopic Pregnancy		☐ Tracheostomy	
☐ Endometrial Ablation		☐ Tubal Ligation	
☐ Eye Surgery		☐ Vascular Surgery	
☐ Gastric Bypass		☐ Other:	
☐ Gastric Surgery		☐ Other:	
☐ Gastrointestinal Surgery		☐ Other:	
☐ Genitourinary Surgery		☐ Other:	
☐ HEENT Surgery		☐ Other:	
☐ Hernia Repair		☐ Other:	

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FAMILY HISTORY (Please indicate the family member, onset age, age of death -if applicable)

Condition	Relation (Mother, Father, Sister, Brother, Son, Daughter, Maternal Grandmother/Grandfather/Aunt/Uncle, Paternal Grandmother/Grandfather/Aunt/Uncle)	Age when Diagnosed	Age of Death
☐ Allergy			
☐ Alzheimer's Disease			
☐ Anemia			
☐ Angina (Heart Problems)			
☐ Anxiety Disorder			
☐ Arthritis			
☐ Asthma			
☐ Blood Coagulation Disorder			
☐ Cerebrovascular Accident			
☐ Chronic Obstructive Pulmonary Disease (COPD)			
☐ Coronary Artery Disease			
☐ Deep Venous Thrombosis (DVT)			
☐ Dementia			
☐ Depressive Disorder (Depression)			
☐ Developmental Disorder			
☐ Diabetes Mellitus (Diabetes)			
☐ Disease of Liver (Liver Problems)			
☐ Disorder of Endocrine System (Endocrine Problems)			
☐ Disorder of Nervous System (Neurologic Problems)			
☐ Disorder of Thyroid Gland (Thyroid Problems)			
☐ Endometrial Carcinoma (Endometrial Cancer)			
☐ Heart Attack (MI)			
☐ Heart Disease			
☐ Heart Failure			
☐ Hypercholesterolemia (High Cholesterol)			
☐ Hypertensive Disorder (Hypertension)			
☐ Immunodeficiency Disorder (Immune Problems)			
☐ Kidney Disease			
☐ Leukemia			
☐ Malignant Lymphoma -clinical (Cancer)			
☐ Malignant Neoplasm of Uterus (Uterine Cancer)			
☐ Malignant Tumor of Breast (Breast Cancer)			
☐ Malignant Tumor of Cervix (Cervical Cancer)			
☐ Malignant Tumor of Colon (Colon Cancer)			
☐ Malignant Tumor of Kidney (Kidney Cancer)			
☐ Malignant Tumor of Lung (Lung Cancer)			
☐ Malignant Tumor of Ovary (Ovarian Cancer)			
☐ Malignant Tumor of Pancreas (Pancreatic Cancer)			
☐ Malignant Tumor of Prostate (Prostate Cancer)			
☐ Mental Disorder (Mental Illness)			
☐ Migraines (Headaches)			
☐ Myocardial Infarction			
☐ Obesity			
☐ Osteoporosis			
☐ Parkinson's Disease			
☐ Psychiatric Problems			
☐ Pulmonary Disease			
☐ Rheumatoid Arthritis			
☐ Seizure Disorder (Epilepsy/Seizures)			
☐ Sleep Apnea			
☐ Substance Abuse (Alcoholo/Substance)			
☐ Sudden Cardiac Death			
☐ Thyroid Problems			
☐ Tuberculosis			
☐ Varices			
☐ Other:			
☐ Other:			
Mother's cause of death (if deceased):			
Father's cause of death (if deceased):			

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SOCIAL HISTORY

Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy Amount:

Smoking Status: ☐ Never ☐ Former (When stopped:) ☐ Current Every Day ☐ Current Some Day

If a current smoker – How much? ☐ None _____Pack(s) Per Day _____Pack(s) Per Week Has smoked since age _____

Illicit Drugs: _____

Living Arrangements: ☐ Alone ☐ Spouse ☐ Kids ☐ Parents

Are you currently working? ☐ Yes ☐ No If no, when did you stop working?

REVIEW OF SYSTEMS (check all that apply)

Constitutional: ☐ Fever ☐ Weight Loss

Skin: ☐ Rash ☐ Birthmarks (more than five)

Eyes: ☐ Eye pain ☐ Wear glasses/contacts

ENT: ☐ Ringing in ears ☐ Sinus infections ☐ Pain swallowing ☐ Trouble swallowing ☐ Grinding teeth ☐ Jaw click

Cardiovascular: ☐ Chest pain ☐ Palpitations ☐ Irregular beat ☐ Murmur

Respiratory: ☐ Shortness of breath ☐ Chronic Cough ☐ Wheezing

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Severe constipation

Genitourinary: ☐ Incontinence of urine ☐ Impotence

Hematology: ☐ Bleeding tendency ☐ Anemia ☐ Easy bruising

Gynecology: ☐ Loss of menstrual period (excluding pregnancy)

Psychiatric: ☐ Depression ☐ Anxiety ☐ Hallucinations

Musculoskeletal: ☐ Joint pains ☐ Joint swelling ☐ Muscle pains

SIGNATURE

Signature of Patient/Patient's Representative: Date:

Print Name of Patient's Representative: Relationship to Patient::