Maryland
Pain & Spine
Associates

Ehab Shalaby, MD, FAAPMR
Board Certified, Interventional Pain Consultant

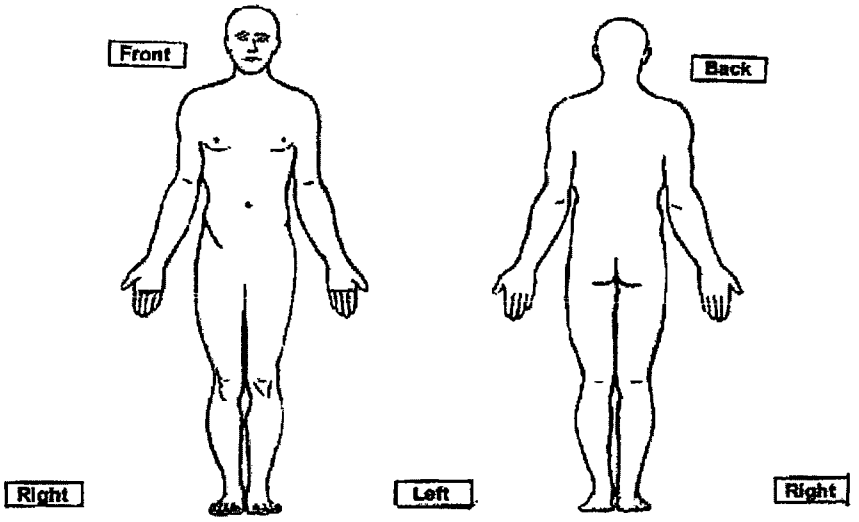
Patient Name: _____ **Male /Female** **Age :** _____ **Today's Date**_____

Home Phone# ( ) _____ **Cell phone # ( )**_____ **e-mail**_____

Home Address: _____**City** _____ **State** ____**Zip Code**_____

Referring Dr._____ **How did you hear about us:**_____

If this is a picture of your body, shade the area(s) where you feel pain. "X" the areas that hurt the most



<u>BODY SITES</u> where you experience pain

Body Site:_____ **Body Site:**_____ **Body Site:**_____

<u>DESCRIBES</u> how is your pain feels like:

Aching	**Sharp**	**Penetrating**	**Throbbing**	**Tender**	**Nagging**	**Shooting**	**Burning**
Stabbing	**Exhausting**	**Miserable**	**Gnawing**	**Tiring**	**Unbearable**	**Tingling**	**Numbing**

<u>IINTESITY</u> of your pain at its, LEAST, AVERAGE and WORST during the last week (Circle the number that best describes)

No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst Imaginable**

<u>TIMING</u> of your pain: **Constant** _____ **Intermittent** _____ **Frequent**_____ **Occasional** _____

What sorts of things make this pain feel <u>BETTER</u> (for example: heat, rest, medicine)?

What sorts of things make this pain feel <u>WORSE</u> (for example: prolonged sitting, standing, walking, etc)?

Patient Initials: _____ Doctor Initials: _____

ASSOCIATED complaints (i.e. numbness, tingling, memory loss, tremor, fatigue, dizziness, loss of vision, visual spots, neck pain, etc.)

LIMITATIONS : Circle the number (s) below that best describes how pain have interfered with your daily functioning this past week.
0 = Does not interfere 10 = Completely interferes

General Activity	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Walking Ability	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Normal Work Routine	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Sleep	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Enjoyment of Life	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

What TREATMENT or MEDICATIONS are you receiving now or have received in the past?
(For example, pain medications, physical therapy, acupuncture, chiropractor, massage,TENS, spinal injections, surgery, etc.)
Circle the number next to the treatment to signify the amount of pain relief or help that treatment is providing or has provided.

Treatment or Medication	**No Relief**	**Complete Relief**	**Check if Receiving Now**
.....	0 1 2 3 4 5 6 7 8 9 10		( )
.....	0 1 2 3 4 5 6 7 8 9 10		( )
.....	0 1 2 3 4 5 6 7 8 9 10		( )
.....	0 1 2 3 4 5 6 7 8 9 10		( )
.....	0 1 2 3 4 5 6 7 8 9 10		( )

WHAT is the cause of your complaint (e.g. Injury, accident, scoliosis, unknown, etc..)_____

WHEN and HOW did your pain started? _____

_____

_____

What TESTS and studies have been done? For example: **MRI, CAT Scan, X-rays, EMG, Discogram, block, etc...**

Test or study	**Month/Year Done**	**Done by**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Initials: _____ Doctor Initials: _____

What DOCTORS have you seen for your pain since it started ?

Doctors Name:	Month/Year Seen	What was done?

Have you ever been dismissed from any pain clinic in the past because of incompliance with their narcotic agreement?

No____ Yes_____ Explain:_____

Current or Past Medical History:

(such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, gynecological history, etc.)

_____

_____

Psychiatric History: (depression, anxiety, bipolar, suicidal attempts,schizophrenia, etc.) _____

_____

Surgical History: (do have any surgery in the past)_____

_____

Family History: e.g. DM, HTN, Back pain, Rheumatoid, cancer, etc _____

Allergies: (Include medication and food allergies) _____

Current Medications: (include vitamins and birth control pills, if applicable)

Medication	Dose	How many a day	Last filled	Doctor

Patient Initials: _____ Doctor Initials: _____

Domestic Situation: With whom do you live? _____
Are you able to take care of yourself? Yes __ No __ If no, please enter name of caregiver _____

Family history for drugs or Alcohol abuse: (explain)_____
History of physical, sexual or psychological abuse _____

Work History: Job:_____ Years Worked:_____ Last Worked:_____
Are you on Disabilty: No____Yes_____ Date started: _____ Cause of disability:_____

Legal Matters: Are you presently involved in a lawsuit (worker comp , No-fault) ? Yes __ No ___
If yes, Date of Injury_____ Explain the accicent:_____

Imprisonment: Yes____ No____ Date: _____

Substance Use: **Which of the following drugs or substances, if any, are you using currently or used in the past?**

Alcohol _____ Marijuana _____Cocaine _____Heroine _____ Amphetamines _____Barbiturates _____

Prescription Drug Abuse_____

Explain:

Are you in a METHADONE Program: NO___ Yes____ If yes, since when_____ what is the current dose_____

Program Name: _____ Contact Person information:_____

SMOKING: Do you presently smoke cigarettes or use tobacco in any form? Yes / No

How many packs do (did) you smoke a day? _____For how many years? _____

If not, did you ever smoke cigarettes or use tobacco in any form? Yes/No

---

Review of System: **Do you have any of the following symptoms? (Circle all that apply)**

Musculoskeletal: Joint swellings, stiffness, muscle spasms.

HEENT: Vision changes, runny nose or voice changes

Respiratory: Difficulty breathing, cough.

GastroIntestinal: Nausea, stomach pain, constipation,

Neurological: Numbness, tingling, drowsiness or seizures

Constitutional: fever, fatigue, weight loss or weight gain

Skin: Itching, rash, sores

Hematological: bleeding tendency

Cardiovascular: Leg swelling, chest pain.

Genitourinary: urine incontinence, blood in urine.

Psychological: sleep changes, depression, anxiety

Other: .....

Are You Pregnant? No ____ Yes_____ Last Menstrual period:_____

Patient Initials: _____ Doctor Initials: _____