THE BIRMINGHAM PAIN CENTER

4515 Southlake Pkwy, Suite 200
Hoover, AL 35242
phone 205·3137246 ❖ fax 205·939·1911

MEDICAL INFORMATION

TODAY'S DATE: _____ SOCIAL SECURITY NUMBER: _____

PATIENT NAME: _____ BIRTHDAY: _____

HEIGHT: _____ WEIGHT: _____ AGE: _____

WHO REFERRED YOU? _____ RACE: _____

PRIMARY CARE PHYSICIAN: _____ SEX: _____

DOCTOR'S ADDRESS: _____

SECTION 1: Pharmacy Information

Pharmacy Name and Address: _____
Pharmacy Phone Number: _____

SECTION 2: Social History

Tobacco Use (including dip, e-cigs, vapor, cigars): Current Former Never

Tobacco-years of use: _____

How much do you smoke (i.e., 1 pack per day)? _____

Are you attempting to quit smoking? Yes No Not Applicable

If you are a former smoker, when did you quit? _____

Do you drink alcohol? Yes No How much? _____ per week/month/year

Do you use any illicit drugs? Yes No What? _____

Marital Status (circle): Single Married Widowed Divorced Separated

Number of Children: _____

Work Status: Full Time Part Time Retired On Disability Applying for Disability Unemployed

Auto related injury? Yes No

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Work related injury? Yes No

Legal Situation: Yes No PENDING

Usual Activity Level: None Limited Moderate Active Very Active

If your problem is not the result of an accident or injury, proceed to the next section.

Injury date: _____ (put specific date if known)

Were you taken off work after your injury? _____ Yes _____ No

If yes, for how long? _____ (give dates if you know them)

Describe briefly the circumstances surrounding the accident or injury - if applicable

_____
_____
_____
_____

SECTION 3: Medications

What you are currently taking and HOW MANY in an average day

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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SECTION 4: Allergies

List all allergies to MEDICATIONS

_____

_____

_____

_____

SECTION 5: Past Medical History

Please check all that apply:

☐ ADD/ADHD	☐ Heart Attack (MI)	☐ Prostate Cancer
☐ AIDS/HIV	☐ Heart Disease (CAD)	☐ Prostate Disease
☐ Addiction/Alcoholism	☐ Heart Murmur	☐ Psyhciatric/Mental Health
☐ Anemia	☐ Heart Valve Disease	☐ Seasonal Allergies
☐ Anxiety Disorder	☐ Heavy Snoring	☐ Seizures/Epilepsy
☐ Arthritis	☐ Hepatitis	☐ Sickel Cell
☐ Asthma	☐ Hernia	☐ Sleep Apnea
☐ Atrial fibrillation	☐ Hiatal Hernia	☐ Stomach Ulcers
☐ Back Injury	☐ High Cholesterol	☐ Stroke/TIA
☐ Bronchitis	☐ High Blood Pressure	☐ Substance Abuse
☐ COPD/Emphysema	☐ Hypotestosteronism	☐ Thyroid Disease
☐ Cancer	☐ Insomnia	☐ Tuberculosis
☐ Chron's disease	☐ Irregular Heart Beat	☐ Ulcerative Colitis
☐ Cirrhosis	☐ Kidney Disease	☐ Vision or Eye Problems
☐ Congenital Heart Defect	☐ Liver Disease	Please List Any Other Problems
☐ Congestive Heart Failure	☐ Multiple Sclerosis	
☐ Decreased Hearing	☐ Muscle Weakness	
☐ Depression	☐ Muscular Disease	
☐ Diabetes	☐ Neck Stiffness	
☐ Easy bruising/bleeding	☐ Osteoporosis	
☐ Fainting	☐ Pacemaker	
☐ Fibromyalgia	☐ Pancreatitis	
☐ GERD/Acid Reflux	☐ Pneumonia	
☐ Glaucoma	☐ Poor Circulation	
☐ Gout	☐ Possibility of Pregnancy	
☐ Headaches	☐ Productive Cough	

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SECTION 6: Past Surgical History

Please check all the operations you have had:

☐	Heart bypass	☐	Knee	**List all other operations**
☐	Heart stents	☐	Hip	
☐	Carotid Artery	☐	Shoulder	
☐	Low back	☐	Rotator Cuff	
☐	Neck	☐	Ankle	
☐	Mid back	☐	Wrist	
☐	Gallbladder	☐	Carpal Tunnel	
☐	Appendix	☐		
☐	Tonsils or Adenoids	☐		
☐	Ear tubes	☐		
☐	Inginual Hernia	☐		
☐	Hysterectomy	☐		
☐	Tubal Ligation	☐		
☐	C-section	☐		
☐	Breast	☐		

SECTION 7: Family History

Family History: CANCER – check any that apply							
Cancer	**Mother**	**Father**	**Brother**	**Sister**	**Son**	**Daughter**	**No FHx**
Brain							
Breast							
Cervical							
Colon							
GI							
Kidney							
Lung							
Ovarian							
Prostate							
Skin							
Testicular							
Thyroid							

Family History: General – check any that apply							
Disease	**Mother**	**Father**	**Brother**	**Sister**	**Son**	**Daughter**	**No FHx**
Alcoholism							
Addiction							
Anemia							
Autoimmune							
Diabetes							

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Heart Disease							
Hypertension							
Lung Disease							
Mental Illness							
Migraine							
Heart Attack							
Kidney Failure							
Seizures							
Stroke							
Thyroid Disease							
Tuberculosis							

SECTION 8: Chief Complaint- Check all that may apply

☐	Neck Pain	☐	Wrist Pain	Right	Left	Both
☐	Mid Back Pain	☐	Elbow Pain	Right	Left	Both
☐	Low Back Pain	☐	Shoulder Pain	Right	Left	Both
☐	Chest Pain	☐	Foot Pain	Right	Left	Both
☐	Abdominal Pain	☐	Ankle Pain	Right	Left	Both
☐	Headache	☐	Knee Pain	Right	Left	Both
☐	Face Pain	☐	Hip Pain	Right	Left	Both
☐	Hand Pain	☐	Other _____			

How long have you had this pain? _____ (circle) days weeks months years

SECTION 9: Pain History

What does your pain feel like (circle all that apply)? Sharp Stabbing Shooting Dull Aching Pressure Burning Tingling Other: _____

Does it go anywhere else? _____

What time of day is it worst (circle one)? Morning Midday Evening Constant

What makes your pain worse? _____

What makes your pain better? _____

Do you have any of the following associated with your pain (circle all that apply)?
Trouble controlling your bladder Trouble controlling your bowels
Difficulty sleeping Anxiety Depression Feeling Tired

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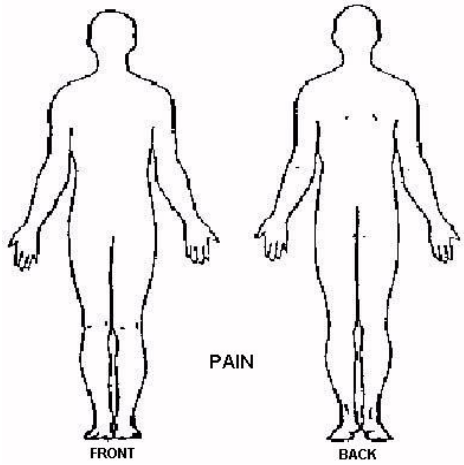
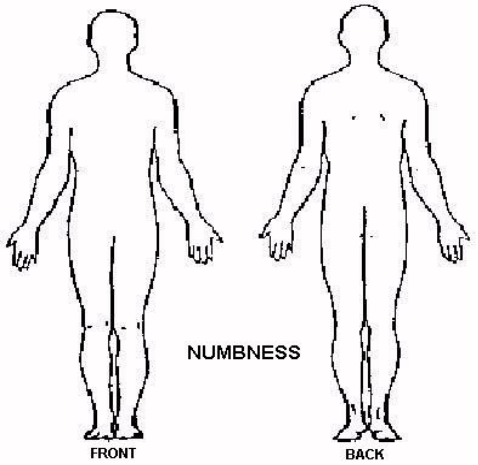
What is your pain score? Current: ____/10 Best: ____/10 Worst: ____/10

Have you tried the following treatments for your pain?

Physical Therapy:	Yes	No
Chiropractor:	Yes	No
Pain Medications:	Yes	No
Steroids:	Yes	No
TENS/muscle stimulator:	Yes	No
Heat/Ice:	Yes	No
Surgery:	Yes	No
Pain Procedures (Epidurals, Nerve blocks, etc.):	Yes	No

Please shade the painful and numb areas in the diagrams below:





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SECTION 10: Other medical complaints

Check all that you FREQUENTLY have

☐ Fever	☐ Pounding Heart Beat	☐ Jaundice	☐ Hallucinations
☐ Night Sweats	☐ Heart Murmur	☐ Rash	☐ Suicidal Thoughts
☐ Weight Changes	☐ Leg Swelling	☐ Laceration	☐ Drug Dependency
☐ Fatigue	☐ Cough	☐ Loss of conciousness	☐ Increased Thirst
☐ Chills	☐ Wheezing	☐ Weakness	☐ Cold Intolerance
☐ Appetite Changes	☐ Coughing up bloood/sputum	☐ Numbness	☐ Increased Hunger
☐ Vision Changes	☐ Nausea	☐ Seizures	☐ Heat Intolerance
☐ Hearing Changes	☐ Vomiting	☐ Dizziness	☐ Swollen Glands
☐ Nose Problems	☐ Constipation	☐ Migraines	☐ Easy Bruising
☐ Sore Throat	☐ Diarrhea	☐ Headaches	☐ Excessive Bleeding
☐ Dry Mouth	☐ Heartburn	☐ Tremor	☐ Runny Nose
☐ Chest Pain	☐ Incontinence	☐ Depression	☐ Sinus Pressure
☐ Shortness of Breath (SOB)	☐ Difficulty Urinating	☐ Sleep Disturbances	☐ Itching
☐ SOB when walking	☐ Blood in Urine	☐ Addiction	☐ Hives
☐ SOB when lying down	☐ Urinary Frequency	☐ Anxiety	☐ Frequent Sneezing

Any other pertinent information you think we need to know._____