Cayuga MEDICAL CENTER
A Member of Cayuga Health System

Patient Sticker

Ithaca Center for Pain Management

New Patient Questionnaire

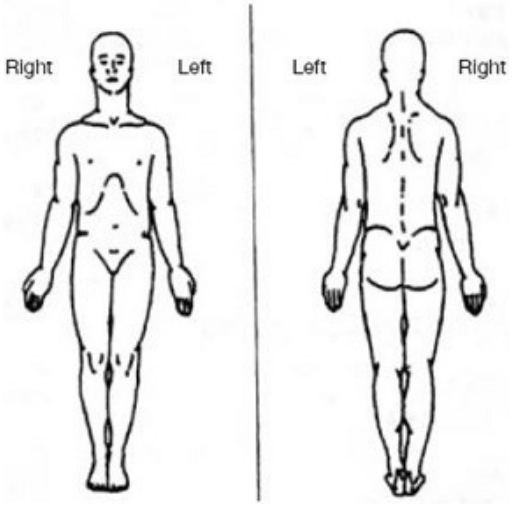
Name _____Age _____Today's Date_____
Address_____

Phone (primary #) _____ (secondary #) _____ (work) _____
Email address (list if we may contact you by email)_____

Person to Notify in case of an emergency_____
Relationship to you _____
May we discuss your medical treatment with this person? ☐ yes ☐ no
Your Education Level ☐ grade school ☐ high school ☐ college ☐ professional degree
Place of Employment_____Job Title/Occupation_____
Are you currently out of work because of your pain?_____ Last day worked?_____
Is your pain the result of a work related injury? ☐ yes ☐no Date of injury_____
Employer _____
Workers' Compensation insurance carrier _____
Workers' Compensation case # _____
Case manager name and phone number_____

Referring Physician _____Primary Care Provider _____
Other physicians you have seen for this pain_____
When did this pain begin? _____
Since the pain first began, has it ☐decreased ☐increased ☐stayed the same
Is the pain the result of a specific event/injury? Please describe _____
_____
_____

Mark on the diagram the areas you have pain



Describe your pain? ☐ aching ☐ burning ☐ sharp
☐ dull ☐ throbbing ☐ tightness
☐ numb/tingly ☐radiating

What number best describes your pain **on average** in the **past week**? 0 1 2 3 4 5 6 7 8 9 10
No pain Worst Pain Imaginable

What number best describes how, during the **past week**, pain has interfered with your **enjoyment in life**? 0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

What number describes how, during the **past week**, pain has interfered with your **general activity?** 0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

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Which of the following tests/treatments have you had for this pain problem? Check all that apply.

☐ MRI/CT ☐ EMG/Nerve Conduction Studies ☐ X-rays ☐ Physical Therapy ☐ Chiropractor ☐ Acupuncture
☐ TENS unit ☐ Injections ☐ Medications ☐ Surgery

How do the following activities affect your pain?

	Increases	Decreases	No Effect
Lying down	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Heat/Ice	☐	☐	☐
Your job	☐	☐	☐

Describe what makes your pain better _____

_____

Describe what makes your pain worse _____

_____

Review of Systems: Please circle any of the following symptoms you are **currently experiencing:**

Constitution (general Health) ☐ No Problems Fever Weight Loss *Other*_____
Eyes ☐ No Problems Vision Problem _____
Ear/Nose/Throat/Mouth ☐ No Problems Difficulty hearing mouth sores sore throat *Other*_____
Cardiovascular ☐ No Problems Chest pain Shortness of Breath Palpitations *Other*_____
Swelling of Feet/Legs Pain in Legs when walking _____
Respiratory ☐ No Problems Cough Wheezing Home Oxygen Use *Other* _____
Gastrointestinal ☐ No Problems Constipation/Diarrhea Nausea Abdominal Pain *Other* _____
Genitourinary ☐ No Problems Incontinence Prostate Problems *Other* _____
Musculoskeletal ☐ No Problems Joint Pain/Swelling Back Pain *Other* _____
Skin ☐ No Problems Rash Wound/Open Sore *Other*_____
Neurological ☐ No Problems Fainting Dizziness Seizures *Other*_____
Endocrine ☐ No Problems Diabetes Thyroid Problem *Other* _____
Psychiatric ☐ No Problems Depression Anxiety *Other* _____

***Females**: Is there any chance you could be **pregnant**? ☐no ☐yes Are you currently **breastfeeding**? ☐no ☐yes*

Height _____ ***Weight*** _____

What **pharmacy** do you use? (list name and location) _____

Please list all medications (including over the counter vitamins/supplements) **you are *CURRENTLY* taking**:

Medication	***Dose***	***Medication***	***Dose***

Please list any other pain medications you have been prescribed and reason for discontinuing them:

_____

_____

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Are you allergic to any of the following? ☐ contrast/IVP dye ☐ shellfish ☐ adhesive tape ☐ latex
Do you have any ***medication*** **allergies**? ☐ no ☐ yes If yes, list medication and reaction below:

Medication	**Reaction**	**Medication**	**Reaction**

Please list any **surgeries** you have had

Surgery	**Date (year)**	**Where**	**Surgery**	**Date (year)**	**Where**

Do you have or have you ever had any of the following diseases or conditions?:

HIV/Aids	Y N	Stroke/TIA	Y N	Asthma	Y N	Thyroid disease	Y N
MRSA/VRE	Y N	Heart attack	Y N	COPD	Y N	Liver problems	Y N
Hepatitis	Y N	Heart murmur	Y N	CHF	Y N	Paralysis	Y N
Tuberculosis	Y N	Artificial valves	Y N	GERD/reflux	Y N	Neck/back pain	Y N
Migraines	Y N	Irregular heartbeat	Y N	Ulcers	Y N	Anxiety	Y N
Seizures	Y N	Pacemaker/defib	Y N	Arthritis	Y N	Depression	Y N
Spinal cord injury	Y N	Anemia	Y N	Diabetes	Y N	Psychiatric problem	Y N
High/low BP	Y N	Bleeding disorder	Y N	Kidney disease	Y N	Drug/alcohol abuse	Y N
Cancer Y N If yes, what kind?_____ Chemotherapy? Y N Radiation? Y N				Sleep Apnea	Y N	Cpap or Bipap Use?	

Any other diseases or conditions?_____

Tobacco/Smoking History

☐ **Never** smoked/used tobacco

☐ **Used to** smoke/use tobacco **Started** (when)_____**Stopped**(when)_____

☐ **Currently** smoke: cigarettes/e-cigarettes/pipe/cigar/chewing tobacco **Amount**_____**Started** when_____
(circle all that apply)

☐ Smoke **marijuana** (recreational or medicinal)

Alcohol Use

Do you drink alcohol?_____How many drinks per week?_____

Do you have any **Family** history of substance abuse**?**	**NO**	**YES**		
Alcohol	☐	☐		
Illegal drugs	☐	☐		
Prescription Drugs	☐	☐		
Personal history of substance abuse**?**	**NO**	**YES**		
Alcohol	☐	☐		
Illegal drugs	☐	☐		
Prescription drugs	☐	☐		
Are you between **16-45 years old?**	☐	☐		
History of preadolescent sexual abuse**?**	☐	☐		
Psychological Disease listed below?	**NO**	**YES**		
Attention Deficit/Hyperactivity Disorder (ADD); Obsessive Compulsive Disorder(OCD); Bipolar Disorder; Schizophrenia	☐	☐		
Depression	☐	☐		

Signature of Patient or Legal Representative _____Date _____