JUPITER MEDICAL CENTER
Jupiter, Florida 33458

PATIENT HISTORY

Date: ______________ Time: ______________

CHIEF COMPLAINT: ______________________________

Allergies:
- ☐ None Known
- ☐ * Medication Allergies: ______________________
- ☐ * Food / Chemical / Latex Allergy: ______________________

CHECK ANY PROBLEMS /CONDITIONS WHICH PERTAIN TO THE PATIENT (Past or Present)

COMMUNICATION	EYES / EARS	INFECTIOUS DISEASES	BOWEL	BEHAVIORAL
☐ Speaks English ☐ Language Barrier ☐ Needs Translator ☐ Clear Speech ☐ Slurred Speech ☐ Other: __________ ☐ Barriers to learning	☐ **No Problems** ☐ Vision Impaired ☐ Glaucoma ☐R ☐L ☐ Cataracts ☐R ☐L ☐ Macular Degeneration ☐ Diabetic Retinopathy ☐ Hearing Impaired ☐ Hearing Aids ☐ Other:	☐ **No Problems** ☐ AIDS ☐ Hepatitis B or C ☐ HIV+ ☐ Tuberculosis ☐ Other __________	☐ **No Problems** ☐ Constipation ☐ Diarrhea ☐ Uses Laxatives ☐ Ostomy ☐ Other: __________ Date of last BM ______	☐ **No Problems** ☐ Anxiety ☐ Depression ☐ Claustrophobia ☐ Alcohol / drug use List __________
SKIN PROBLEMS	**GI / NUTRITION**	**BLOOD / LIVER**	**BLADDER / KIDNEY**	**REPRODUCTIVE**
☐ **No Problems** ☐ Rashes ☐ Wounds ☐ Breakdown ☐ Hx of Bruising ☐ Shingles ☐ Pressure sore	☐ **No Problems** ☐ Ulcers ☐ Nausea / Vomiting ☐ Weight gain, loss ☐ Hiatal Hernia ☐ Indigestion ☐ Other: __________	☐ **No Problems** ☐ Cirrhosis ☐ Anemia ☐ Bleeding Problems ☐ Prior Transfusions ☐ Other: __________	☐ **No Problems** ☐ Dialysis ☐ Catherization ☐ Incontinence ☐ Stones ☐ Prostate Problem ☐ Other: __________	☐ **No Problems** ☐ Discharge / Bleeding ☐ Date LMP ____ ☐N/A ☐ Pregnant Due ______ Self-Breast Exam ☐Y ☐N ☐ Last PAP ☐ Vasectomy ☐ Other: __________
CARDIAC	**RESPIRATORY**	**HEAD/ NECK**	**VASCULAR**	**ENDOCRINE**
☐ **No Problems** ☐ Chest Pain ☐ MI ☐ Irregular Beats/A. Fib ☐ Pacemaker / AICD ☐ BP Problem ☐ Valve Prosthesis ☐ Heart Surgery ☐ CHF ☐ Thrombolytic Therapy	☐ **No Problems** ☐ Pneumonia ☐ Emphysema ☐ COPD ☐ Asthma ☐Cough ☐ Bronchitis ☐ SOB ☐ Sleep Apnea ☐ Other: __________	☐ **No Problems** ☐ Stroke __________ ☐ Seizures __________ ☐ TIA ☐ Dizziness/fainting ☐ Headache ☐ Jaw or neck problem ☐ Freq forgetfulness ☐ Other:	☐ **No Problems** ☐ Phlebitis ☐ DVT ☐ Peripheral Pulse Present ☐ Other __________	☐ **No Problems** ☐ Thyroid ☐ Diabetes ☐Uses insulin ☐ Other __________

NEURO / MOBILITY
- ☐ **No Problems**
- ☐ Numbness*
- ☐ Weakness*
- ☐ Paralysis*
- ☐ Pain on movement
- ☐ Gait unsteady*
- ☐ Hx of Fall *
- ☐ Arthritis

(* Fall Precautions)

Patient uses
- ☐ Crutches
- ☐ Walker
- ☐ Cane
- ☐ Prosthesis
- ☐ Wheelchair
- ☐ PT Referral

PAST / CURRENT MEDICAL SURGICAL HISTORY

☐ List Surgeries within last 10 years: ______________________

☐ Heart / valve prosthesis __________ ☐ Implants __________ ☐ Internal Metal / any type ________

☐ Other ______________________________________

Problems with prior surgeries / anesthesia ☐ NA ☐ Yes ☐ No If yes describe: ________________

____

Received complimentary /alternative care from anyone in the past 12 months?

☐ Yes ☐ No If yes describe: ______________________________

VALUABLES and ASSIST DEVICES

Valuables to declare: ☐ No ☐ Yes If yes, describes ______________________

____

☐ Valuables given to family member (name) ______________________

☐ Dentures / Partials ______U ______ L ☐ Glasses / Contact Lenses

☐ Hearing Aid ______R ______L ☐ Other __________

Information received from: ______________________ Relationship: ______________________

Signature: ____

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JUPITER MEDICAL CENTER
Jupiter, Florida

PAIN MANAGEMENT CENTER
PATIENT HEALTH ASSESSMENT

Today's Date: ____________________

PLEASE COMPLETE IN PEN

Your Name: Last____________________ First: ____________ Middle________

Date of Birth:____________________ Age:______ SS #____________________

Height: ____________ Weight:____________

Address:____________________ City: ____________State:______ Zip:________

Home Phone: ____________________

Referring Physician:____________________ Specialty:____________________

Address:____________________ City: ____________State:______ Zip:________

Phone: ____________________

Primary Care Physician: ____________________

Address:____________________ City: ____________State:______ Zip:________

Phone: ____________________

Health Care Insurance Carrier: ____________________

Are you currently employed? ______ Yes ______ No Occupation:____________________

Employed by: ____________________ Phone: ____________________

If unemployed, for how long? ____________ Is this due to your pain? ____ Yes ____ No

Do you receive disability benefits?____________ If so, what type?____________

What is your level of education?____________

Marital status:____________ # of children ________ With whom do you live? ____________

Spouse/S.O. Name:____________________ If Minor, Parent's Name: ____________

Person to Contact in Case of Emergency:____________________ Phone____________

What brings you to the Pain Management Center at this time?____________________

____

When did you first experience your pain and under what circumstances? ____________

____

Was your pain originally due to a work-related injury?____________________

____

How often does your pain occur and how long does it last? ____________________

____

Is your pain related to any particular activities? ____________________

____

4HP

JUPITER MEDICAL CENTER
Jupiter, Florida

Date: ______________________

Patient Name: ______________________

Are you presently in litigation related to your pain? ______________________

____

Please check off any diagnostic tests you have undergone for this problem.

	DATE	HOSPITAL	RESULTS
____ X-Rays			
____ CAT Scan			
____ MRI			
____ EMG			
____ Myelogram			
____ Other (specify)			

Please list any other doctors you have consulted regarding this problem.

DOCTOR	SPECIALTY	DATE

Please check any treatments you have previously undergone for this problem:

____ Surgery

____ Medications (specify)

____

____

____

____ Nerve blocks

____ Steroid injection

____ Trigger point injections

____ Bed rest

____ Physical Therapy

____ Massage

____ Chiropractor

____ Ultrasound

____ Acupuncture

____ Biofeedback

____ Hypnosis

____ Relaxation

____ Exercise

____ Traction

____ Heat or cold

____ TENS

____ Other (specify)______________________

Please check any past or present medical conditions or complaints that apply to you.

____ Angina

____ Asthma

____ Bleeding Tendencies

____ Cancer

____ Diabetes

____ Heart Failure

____ Hypertension

____ Irregular Heart

____ Kidney Problems

____ Lung Disease

____ Pacemaker

____ Psychiatric Problems

____ Stroke

____ Other______________________

____ Heart Attack

JUPITER MEDICAL CENTER
Jupiter, Florida

Date: ______________________________

Patient Name: ______________________

Please list *all* medications you are currently taking including "over-the-counter medications".

MEDICATION	REASON TAKEN	HOW OFTEN

Please list any allergies to medications.

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Please list any prior surgeries you have undergone.

Type of Surgery	Date	Hospital	Physician

Have you or any family members had any problems with anesthesia? ______ Yes ______ No

(If yes, please describe) ______________________________

____

Has your pain interfered with your:

Appetite ____ Yes ____ No If yes, ______ Increased ______ Decreased

Self Care (Bathing, Dressing, etc.) ____ Yes ____ No

Usual level of activity ____ Yes ____ No

Sexual activity ____ Yes ____ No

Sleeping ____ Yes ____ No If yes, ____ falling asleep
____ staying asleep
____ early awakening

Do you have enough energy to perform desired activities during the day? ____ Yes ____ No

Do you drink alcohol? ____ Yes ____ No ________ drinks per week

Do you smoke? ____ Yes ____ No ________ packs per day

Do you use recreational drugs? ____ Yes ____ No ______________________ what and how much

Has your pain interfered with your ability to cope with stress? ____ Yes ____ No

How well do you handle stress in your life? ______________________________

____

Do you practice any religion or have a personal faith system which helps you to cope better with your pain? ______

____

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Date: ______________________

Patient Name: ______________________

Please mark an 'X' at the appropriate point on the line which describes how much stress you are experiencing presently.

No Stress________________ I ________________ Most stressful time in my life

Pain can be very difficult to describe. It is helpful to compare the intensity of your pain at different intervals. Please rate the **Intensity** of your pain on a scale from 0 to 10.

0 represents no pain *10 represents the worst pain you can imagine*

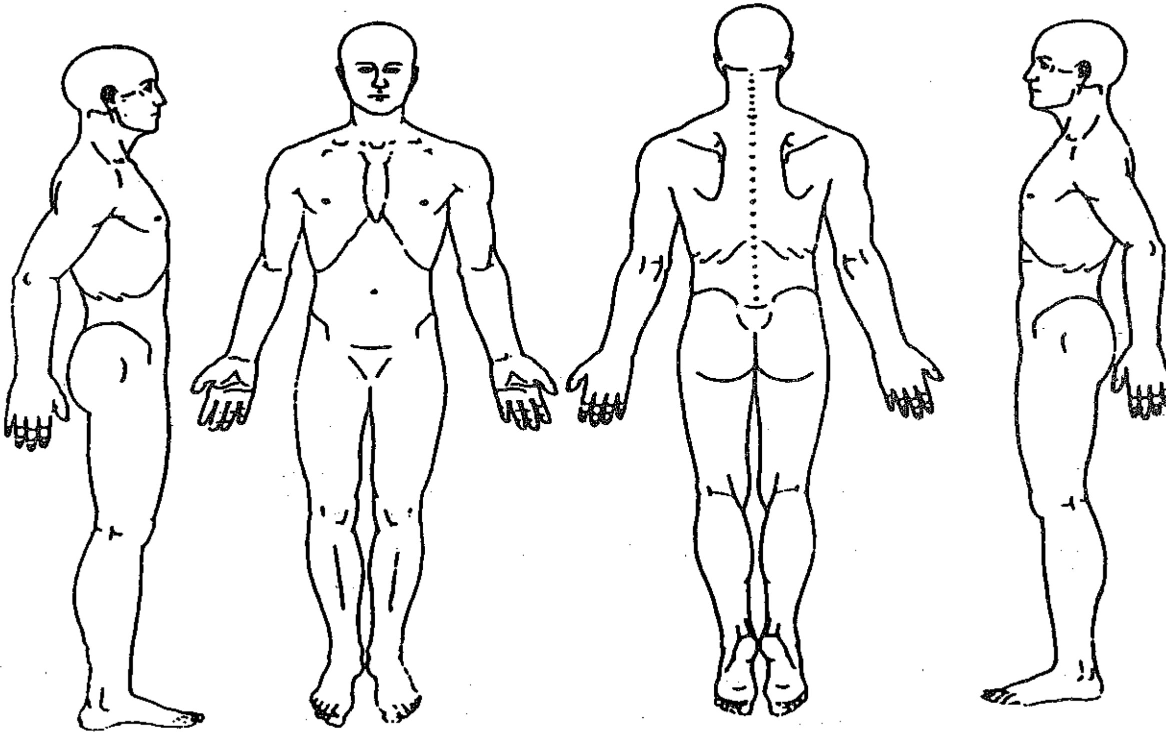
What is your pain now? _______

What is your pain at rest? _______

What is your pain with activity? _______

On subsequent visits, we will refer to the 0 - 10 scale and ask you to rate your pain.

On the drawings below, please mark an 'X' in each place you are experiencing pain.



I have read and understand the above questionnaire and certify that the answers given by me (or the legal representative for me) are correct to the best of my knowledge.

SIGNED: ______________________________ DATE: ______________

Anesthesiology of Jupiter, PA
1210 S Old Dixie Hwy, 2nd Floor
Jupiter, FL 3458
Phone: 561-743-5073 Fax: 561-743-5074

MR#:

DOB: / /

Pain Management Center
Current Medication List

ALLERGIES:

Date	Medications (Including Herbals, Vitamins and OTC medications)	Dosage	Frequency	Date D/C'd	Reviewed by (initials)

1MAR

Form # jmc9296