PainandRecoveryClinic
San Antonio, TX

6851 Citizens Parkway, Suite 225
San Antonio, TX 78229
Phone: 210-299-1444
Fax: 210-299-1446

Patient Medical Information - Please Print Clearly

Patient Name: ____ **Date:** ________
First Middle Last

Age: ______ **Referring Physician:** ____

Chief Complaint: (Please answer questions, check appropriate space or circle where requested)

Where is pain? ____

On a pain scale of 1 to 10, at what level do you consider your pain to be?

Please circle one: 1 2 3 4 5 6 7 8 9 10
(Least Pain) (More Pain)

Does your pain go down your arms? Yes ____ No ____ If Yes, Left Arm ____ Right Arm ____

Does your pain go down your legs? Yes ____ No ____ If Yes, Left Arm ____ Right Arm ____

Do you have any numbness or tingling sensations? Yes ____ No ____ If Yes, where? ________________

____

Are you having headaches? Yes ____ No ____ If Yes, please explain ______________________

____

Does your pain interfere with your work or occupational activities? Yes ____ No ____

If Yes, please explain: ____

____

Please describe any other symptoms you have: ______________________________

____

HISTORY OF PRESENT ILLNESS:

When did your illness or injury occur? ______________________________________

Describe the onset of your illness or the accident in detail: ________________________

____

____

____

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Where you unconscious as a result of this illness or injury? Yes ____ No ____

If Yes, for approximately how long? ____

Where you taken to the emergency room because of this illness or injury? Yes ____ No ____

Hospital Name: ____

Address: ______________________________ City: ____________ State: ________

Where X-rays taken? Yes ____ No ____ If Yes, what areas? ______________________________

____

Please state results if known: ____

Where you given any medications? Yes ____ No ____ If Yes, what medications? ____________

____

Where you hospitalized? Yes ____ No ____ If Yes, where? ______________________________

____

Have you seen any other physicians for this illness or injury? Yes ____ No ____ If Yes, please list below:

Name of Physician	Dates of Service

Have you had any additional testing (MRI, CT Scan, EMG/NCS, Myelogram, EKG, etc.)? Yes ____ No ____
If Yes, please complete the following:

Type of Test	To What Area	Date	Name and Address of Facility

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Have you had any physical therapy because of your illness or injury? Yes ____ No ____

If Yes, what area? ____

Did it help? Yes ____ No ____ How? ____

Have you had any injections or surgical procedures for your illness or injury? Yes ____ No ____
If Yes, please complete the following:

What Was Done	Date Done	Name and Address of Facility
______________________	________	______________________
______________________	________	______________________

PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following:

A. Cancer/Type _______________/______________ Yes ____ No ____ Resolved/Remission Yes ____ No ____

B. Cardiopulmonary Disease	Yes ____ No ____	Medication	Yes ____ No ____
C. Hypertension	Yes ____ No ____	Medication	Yes ____ No ____
D. Diabetes	Yes ____ No ____	Insulin	Yes ____ No ____
E. Arthritis	Yes ____ No ____	Medication	Yes ____ No ____
F. Migraine Headaches	Yes ____ No ____	Frequency	Yes ____ No ____
G. Seizures	Yes ____ No ____	Frequency	Yes ____ No ____
H. HIV/AIDS	Yes ____ No ____	Medication	Yes ____ No ____

I. Others: ____

Have you had any of the following injuries:

A. Broken or Cracked Bones	Yes ____ No ____	Date _______	Area ______________________
B. Strains or Sprains	Yes ____ No ____	Date _______	Area ______________________
C. Dislocations	Yes ____ No ____	Date _______	Area ______________________
D. Concussions	Yes ____ No ____	Date _______	Area ______________________

E. Others: ____

SURGERIES:

Have you had any of the following surgeries:

A. Tonsillectomy	Yes ____ No ____	Date ________________
B. Appendectomy	Yes ____ No ____	Date ________________
C. Hysterectomy	Yes ____ No ____	Date ________________
D. Cholecystectomy (Gall Bladder Removal)	Yes ____ No ____	Date ________________
E. Cesarean Section	Yes ____ No ____	Date ________________

Please list other surgical procedures and dates not listed above: ______________________________

Do you have any metal implants? Yes ____ No ____ If Yes, where? ______________________________

Do you have a pacemaker Yes ____ No ____

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Allergies:
Are you allergic to any of the following:

A. Penicillin/Sulfa Drug Yes ____ No ____
B. Aspirin/Codeine/Morphine Yes ____ No ____
C. Iodine Yes ____ No ____
D. Others ____

Are you allergic to foods? Yes ____ No ____ If Yes, which ones? ______________________
____

Medications:
Please list all medications you are taking along with dosage.

______________________ ______________________
______________________ ______________________
______________________ ______________________

Additional Information:

Marital Status: Single ____ Married ____ Divorced ____ Widow ____ Other _____

Do you have children? Yes ____ No ____ If Yes, how many? ____________________

Do you smoke? Yes ____ No ____ If Yes, how many? ____________________

Do you drink alcoholic beverages? Yes ____ No ____ If Yes, how much and how often? ________________

What is your occupation? ____________________________

Describe the physical activities required by your job: ______________________________
____
____
____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Pain and Recovery of San Antonio of any health changes.

____ ____________________
Signature of Patient, Guardian or Personal Representative — Date

____ ____________________
Please Print Name of Patient, Guardian or Personal Representative — Relationship to Patient

For Office Use Only

Reviewed: Yes ____ No_____ Approved: Yes ____ No ____ Initials: ________ Date: ____________ (mm/dd/yyyy)