

# Premier



PAIN MANAGEMENT, LLC

## PATIENT HISTORY

PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	AGE	HEIGHT	WEIGHT
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## PATIENT MEDICAL HISTORY

Alcohol consumption?..... <input type="checkbox"/> Yes <input type="checkbox"/> No How much? _____	CVA / Stroke..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Depression..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney problems..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Latex sensitive..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Dialysis..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Bladder disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinusitis..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel disorder..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting spells..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Smoking..... <input type="checkbox"/> Yes <input type="checkbox"/> No How much? _____
Bronchitis..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach disorders... <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Had a cold recently.. <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems... <input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing problems... <input type="checkbox"/> Yes <input type="checkbox"/> No	Tremors/Parkinson's <input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Pregnant..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (B or C)... <input type="checkbox"/> Yes <input type="checkbox"/> No	
	HIV/AIDS exposure <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please list all current medications and dosages: \_\_\_\_\_

Please list any medications that you have a history or allergic reaction to: (list what your reaction was): \_\_\_\_\_

Please list all previous surgeries: \_\_\_\_\_

\_\_\_\_\_

## CARDIOVASCULAR HISTORY

Do you have high blood pressure?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any heart disease?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have palpitations?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you suffer from irregular heartbeats?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have fast heartbeats?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you suffer from angina?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a heart murmur?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a cardiac pacemaker?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you suffer from chest pain?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a stroke?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a heart attack?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	

## FAMILY MEDICAL HISTORY

Please list any family medical history: (living or deceased) What family member?

Cancer..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Relation: _____	<input type="checkbox"/> Living <input type="checkbox"/> Deceased
Heart disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Relation: _____	<input type="checkbox"/> Living <input type="checkbox"/> Deceased
High blood pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Relation: _____	<input type="checkbox"/> Living <input type="checkbox"/> Deceased
Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Relation: _____	<input type="checkbox"/> Living <input type="checkbox"/> Deceased
Depression/Mental disorders... <input type="checkbox"/> Yes <input type="checkbox"/> No	Relation: _____	<input type="checkbox"/> Living <input type="checkbox"/> Deceased
Other _____	Relation: _____	<input type="checkbox"/> Living <input type="checkbox"/> Deceased
Other _____	Relation: _____	<input type="checkbox"/> Living <input type="checkbox"/> Deceased
Other _____	Relation: _____	<input type="checkbox"/> Living <input type="checkbox"/> Deceased

PATIENT SIGNATURE	DATE
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