Advanced Pain Management

Patient Name: _____DOB:_____

SS#_____

Instructions: Please fill in the bubble completely next to each item which applies to you.

******* Please DO NOT use a check mark or "X" to mark the bubbles ****** ***(SOC HX)***

Household

Marital Status: O Single O Married O Widowed O Divorced O Not Answered

Level of Education: O Not finished High School O Finished High School O Not Finished College

O Finished College O Professional Schools/Masters/PhD O Not Answered

Social History

Do you exercise? O Yes

Tobacco Use (ie: Cigarettes, Cigars, Chew, Pipe): O Yes Alcohol Use: O Yes

Family History

Spouse? O Yes Children? O Yes

Drugs

Have you used drugs other than those prescribed for medical reasons in the past 12 months? O Yes O No

Hospitalization

Any in the past 1 year? O Yes In the past 5 years? O Yes

For Surgery? O Yes For other Medical Conditions? O Yes

Surgical History

Cholecystectomy O Yes Appendectomy O Yes Tonsillectomy O Yes Cataract(s) O Yes

Aneurysm repair O Yes Bowel surgery O Yes Cardiac Catheterization O Yes

C-section O Yes Hysterectomy/or Abdominal O Yes Rotator cuff tear repair O Yes

Knee replacement O Yes Artificial hip joint O Yes Spine Surgery O Yes

Pain pump O Yes Spinal cord stimulator O Yes