University of Maryland Rehabilitation & Orthopaedic Institute

PAIN MANAGEMENT CENTER
PATIENT QUESTIONNAIRE

We are interested in understanding more about your pain. Please help us by filling out this questionnaire.

Date: _____

Name:_____ Date of Birth: _____

Primary Care Physician:

Name:_____

Address: _____

_____

_____

Phone: _____

Referring Physician (if different):

Name:_____

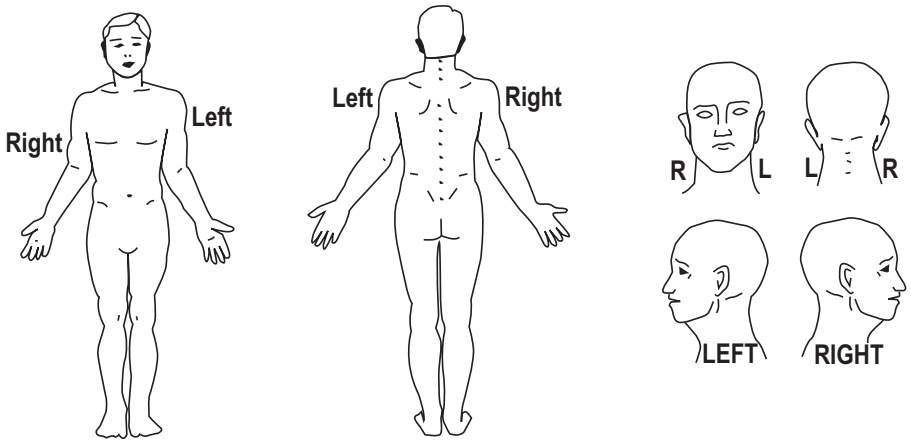
Address: _____

_____

_____

Phone: _____

Please use the diagram below to indicate where your most painful areas are located.



1. When did your pain problem begin, or if your pain is related to a specific injury, what date did the injury occur? Month: _____ Day : _____Year:_____

2. How did your pain first start? (Car accident? Fall? Job related injury? Etc.)

_____

3. Please list **all past surgeries/hospitalizations:** If more room is needed, use the back side of this paper.

DATE	SURGERY OR REASON FOR HOSPITALIZATION

4. Please list all your **current** medications, including "over the counter medications" below, **or provide a medication list**. Use the back side of this paper, if needed.

MEDICATION	STRENGTH (how many milligrams?)	How often do you take this medication?

5. Please list all of your ALLERGIES: _____

Please circle your answer:

6. Have you ever been seen by another pain specialist? **Yes** **No**

   If so, what is the name of the doctor or practice?_____

7. Are you currently working? **Yes** **No** **Retired**

   Describe your current or past occupation: _____

8. Are you being treated under Worker's Compensation? **Yes** **No**

9. Are you currently receiving or applying for disability benefits? **Yes** **No**

10. Are you involved in any legal action related to your pain problem or considering it in the future? **Yes** **No**

11. Have you ever experienced any of the following?
Please circle Yes or No for each problem.

Yes	**No**	Blurry vision
Yes	**No**	Glaucoma
Yes	**No**	Ringing in your ears
Yes	**No**	Clenching your teeth
Yes	**No**	Tightness in your chest or chest pain
Yes	**No**	Heart disease or irregular heart beats
Yes	**No**	Need to sleep sitting up in order to get your breath
Yes	**No**	Difficulty breathing
Yes	**No**	Emphysema or asthma
Yes	**No**	Abdominal pain
Yes	**No**	Stomach ulcers or gastritis
Yes	**No**	Irregular bowels
Yes	**No**	Irritable bowel disease
Yes	**No**	Blood in your stools
Yes	**No**	Pelvic pain
Yes	**No**	Frequent urination
Yes	**No**	Inability to urinate
Yes	**No**	Seizures
Yes	**No**	Frequent headaches
Yes	**No**	Episodes of blacking out or passing out
Yes	**No**	Unexplained fevers
Yes	**No**	Excessive fatigue
Yes	**No**	Difficulty falling or staying asleep
Yes	**No**	Rashes
Yes	**No**	Rheumatoid arthritis, lupus, sarcoid or scleroderma
Yes	**No**	Diabetes
Yes	**No**	Thyroid problems
Yes	**No**	Depression
Yes	**No**	Anxiety

I have reviewed this list with the patient_____

(For physician use only) Physician Signature/Date and Time