## Hess Orthopedics – Pain Management New Patient Questionnaire

Welcome to Hess Orthopedics Pain Management Clinic! Please complete this form as it helps us best treat your pain. Please answer every question the best you can. We use ALL of the answers to these questions to tailor treatment to your specific condition. Also, please bring your medications (or a list of them with name and dosing instructions) and any imaging records (printed reports and images on CD) to your appointment. Thank you for helping us to help you!

Contact Information
Full Name:
Date of Birth:
Mailing Address:
Phone Number: ()
s it okay for us to leave a voicemail or message with laboratory or imaging results? YES NO
Emergency Contact:
Emergency Contact Phone Number: ()
s it okay for us to share health information (such as laboratory or imaging results) with your emergency contact? YES NO
Preferred Pharmacy:
Γell Us About Your Pain
Where is most of your pain? Please draw on diagram to the right:

What is your average pain score today? Please circle a number below.												
0 No pai		2	3	4	5	6	7	8	9 Severe	10 pain		
When	did you	ır pain s	start? ]	Be as spo	ecific as	s possib	ole					
Did yo			_			_				e what happene		
How w	vould y	ou desc	ribe yo	our pain s	Please	e circle	all that	apply.				
Sharp		Aching	5	Cramp	oing	Du	11	Burni	ing	Shooting	Other:	
What makes your pain worse?												
What makes your pain better?												
Functi	onally,	what do	oes you	ır pain li	mit you	the mo	ost from	doing?	·			
Please tell us if you have any other symptoms. Please circle YES or NO.												

Fever	YES	NO
Blurry vision	YES	NO
Hearing loss	YES	NO
Chest pain	YES	NO
Shortness of breath	YES	NO
Nausea or vomiting	YES	NO
Constipation	YES	NO
Excessive thirst	YES	NO
Bladder incontinence	YES	NO
Bowel incontinence	YES	NO
Weakness (in arms or legs)	YES	NO
Anxiety	YES	NO
Depression	YES	NO
Rash	YES	NO
Easy bleeding or bruising	YES	NO
Allergic reaction	YES	NO

What laboratory tests (i.e. blood work), imaging (i.e. CT, MRI, ultrasound), or other studies (i.e. EMG) have you had for your pain?

Test (i.e. MRI, CT)	Year	hospital or clinic performed)
What medications (including over-the	e-counter medications, vitamins, he	erbs) are you taking <b>for pain?</b>
What medications (including over-the	e-counter medications, vitamins, he	erbs) have you tried for pain?
What injections have you had <b>for you</b>	<u>i pain</u> ?	
What surgeries have you had <b>for you</b>	r pain?	
·	<del></del>	

What else has been done to treat your pain?					
Is there any pending litigation regarding your condition	n? YES NO				
Is there still a pending disability claim for your condition? YES NO					
Is there still a pending worker's compensation claim for your condition? YES NO					
Please list all medical problems/diagnoses and the year you were diagnosed (including mental health diagnoses).					
Diagnosis	Year Diagnosed				

## Please list all surgical procedures you have had and the year it was performed.

Surgery (including side, if applicable)	Year Performed

## Please list ALL current medications, dose and frequency.

Medication	Dose	Frequency (i.e. 3 times per day)

## Please list ALL medications that you are allergic to:

Medication	Type of Reaction (i.e. anaphylaxis, rash)
Are you pregnant? YES NO	
Do you use tobacco products (i.e. smoke cigarettes/ciga	ars, chew tobacco)? YES NO
Do you drink alcohol? YES NO Frequency?	
Do you use any other drugs (illegal or legal)? YES  If so, what drugs?	
Have you ever been diagnosed with or had treatment for	or alcohol or drug abuse? YES NO
Has anyone in your family ever been diagnosed with or	had treatment for alcohol or drug abuse? YES NO