Southwest Pain Group
Put your Pain in the Past.

Short Form History Intake

Name_____Date _____

Age _____ Height _____ Weight _____

Allergies (list): _____

_____

_____

Are you allergic to x-ray dye or contrast?	YES	NO
Are you allergic to iodine or shellfish?	YES	NO
Are you allergic to tape or adhesives?	YES	NO
Do you have an allergy to Latex?	YES	NO
Do you smoke?	YES	NO
Do you drink alcohol?	YES	NO

MEDICATIONS: (list)

MEDICATION	DOSE	FREQUENCY

Do you take any blood thinners (anti-coagulants)? YES NO

If so, what is the name of this medication? _____

PAST MEDICAL HISTORY: (list) _____

_____

_____

PAST SURGICAL HISTORY: (list) _____

_____

_____

REVIEW OF SYSTEMS: Please draw a **circle** around any symptoms or conditions in this section which you have had or now have. If your symptom(s) or condition(s) is not listed, please write it in.

GENERAL: anemia, psoriasis or other skin problems, osteoporosis, night sweats, nosebleeds, arthritis, HIV / AIDS, Tuberculosis (TB). **Other:**

NEUROLOGICAL: unusual head or neck tension, seizures, paralysis of limbs, numbness or tingling of body parts, severe lapses in memory, blackouts, dizziness, blurred vision, strokes, frequent headaches, seizures.
Other:

CARDIOVASCULAR: heart disease, chest pain, high blood pressure, heart attack, abnormal or fast heartbeat, atrial fibrillation, arrhythmia, calf cramps, blood clots, swelling of ankles or feet, bleeding disorder.
Other:

RESPIRATORY: wheezing, asthma, hoarseness, pneumonia, cough, emphysema, shortness of breath with little exercise or at rest. **Other:**

GASTROINTESTINAL: digestive difficulties, reflux or GERD, nausea, vomiting, diarrhea, constipation, bowel incontinence, hepatitis, ulcers. **Other:**

GENITOURINARY: urinary incontinence, pain with urination, urgency, dribbling, difficulty starting or passing urine, flank pain, difficulty with sexual functioning. **Other:**

(Female patients only):

Is it possible that you are pregnant? YES I NO
Are you planning to become pregnant? YES I NO

EMOTIONAL / PSYCHOLOGICAL: depression, excessive worrying, insomnia, nervous exhaustion, frequent crying, nervous breakdown, frequent nightmares. **Other:**