Medical Office Building

1100 Goethals Drive, Richland

DIRECTIONS

From **I-182**

Take **George Washington Way** (Exit 5B)

Turn left on **Swift Boulevard**

Turn right on **Goethals Drive** (third right)

1100 Goethals Drive is one block on the right

First Floor

Infectious Disease
(509) 942-2360

Neuroscience Center
(509) 942-3080

Second Floor

Ear, Nose and Throat
(509) 942-3288

Endocrinology
(509) 942-3288

Foot and Ankle
(509) 942-3288

General and Colorectal Surgery
(509) 942-3288

Nephrology
(509) 942-3288

Urology
(509) 942-32880

Tri-Cities Laboratory
(509) 946-4887

Third Floor

Inland Cardiology
(509) 942-3272

Cardiothoracic Surgery
(509) 942-3095

Interventional Radiology
(509) 942-3095

Pulmonology
(509) 942-3095

Vascular Surgery
(509) 942-3095

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Your answers to this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. Thank you!!

Name:_____ Date of Birth**:** _____Height**:** _____ Weight: _____

REASON FOR VISIT: _____
REFERRING PHYSICIAN:_____
PRIMARY CARE/FAMILY PHYSICIAN: _____

DRUG ALLERGIES: please list reaction ○ NKDA (No known drug allergies)

Type/Drug: _____ Reaction: _____
Type/Drug: _____ Reaction: _____
Type/Drug:_____ Reaction: _____

PRESENT MEDICATIONS: (Please include any aspirin, over the counter vitamins, herbs and other supplements)

☐ Not taking any medication at this time

MEDICATION / DRUG NAME DOSE (mg) FREQUENCY (times per day)

_____
_____
_____
_____
_____
_____
_____
_____

Have you tried or been prescribed any of the following medications in the past for your pain?

- ☐ Steroids(e.g. Prednisone, Medrol Dosepak)
- ☐ Naprosyn (Naproxen)
- ☐ Tofranil (imipramine)
- ☐ Lexapro
- ☐ Paxil
- ☐ SOMA
- ☐ Zoloft (sertraline)
- ☐ Darvon / Darvocet
- ☐ Ultram / Ultracet
- ☐ Vicoden /Lortab /Norco
- ☐ Ibuprofen (Motrin, Advil)
- ☐ Desyrel (Trazadone)
- ☐ Lyrica
- ☐ Prozac
- ☐ Valium (Diazepam)
- ☐ Serzone (Nefazodone)
- ☐ Baclofen (Lioresal)
- ☐ Codeine/ Tylenol #3 or 4
- ☐ Duragesic (Fentanyl Patch)
- ☐ Dilaudid (Hydromorphone)
- ☐ Elavil (Amitriptyline)
- ☐ Celebrex
- ☐ Sinequan (Doxepin)
- ☐ Neurontin (Gabapentin)
- ☐ Effexor (Venlafaxine)
- ☐ Klonopin (Clonezapam)
- ☐ Wellbutrin (Buproprion)
- ☐ Oxycontin (Oxycodone)
- ☐ MSContin /Kadian /Avinza (Morphine)
- ☐ Percocet/ Percadan/ Tylox

PAST MEDICAL HISTORY: (Indicate whether you have had the following, with dates if possible)

- ☐ Anemia
- ☐ Acid Reflux (GERD)
- ☐ High Blood Pressure
- ☐ AIDS/HIV
- ☐ Hepatitis A/B/C
- ☐ Pneumonia
- ☐ Seizure Disorder
- ☐ Depression
- ☐ Heart Attack
- ☐ Asthma
- ☐ Irregular Heart Beat
- ☐ Heart Disease
- ☐ Pulmonary Embolus /DVT
- ☐ Other:_____
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Arthritis
- ☐ Stroke
- ☐ Osteoporosis
- ☐ Tuberculosis
- ☐ Kidney Failure
- ☐ Stomach Ulcers
- ☐ High Cholesterol
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Emphysema/COPD

SURGICAL HISTORY: List all prior operations with dates

DATE TYPE OF SURGERY HOSPITAL / CITY

_____
_____
_____
_____
_____

FAMILY HISTORY: ☐ Adopted
Mother: ☐ Alive ☐ Deceased _____Age (Now or at Death)
Cause of Death/Medical problems: _____
Father: ☐ Alive ☐ Deceased _____ Age (Now or at Death)
Cause of Death/Medical problems: _____

Please indicate family members (parent, sibling, maternal or paternal grandparent, aunt or uncle) with any of the following conditions:

☐ *Cancer*_____
☐ Heart Disease_____
☐ High Blood Pressure_____
☐ Malignant Hyperthermia_____
☐ Aneurysms_____
☐ Stroke_____
☐ Diabetes_____
☐ Epilepsy_____
☐ Congenital Problems_____
☐ Brain Tumors_____
☐ Problems with Anesthesia_____
☐ Other_____

SOCIAL HISTORY:
Are you: ☐ Working ☐ Full-time ☐ Part-time ☐ Modified Duty
Occupation: _____Employer: _____
☐ Retired Previous occupation: _____
☐ Disabled Previous occupation: _____
Years of education/highest degree: _____
Marital Status: ☐ Single ☐ Partner/Married ☐ Divorced ☐ Widowed ☐ Other: _____
Spouse/Partner's name: _____
Number of children/ages: _____
Is there a possibility you may be pregnant? ☐ Yes ☐ No If yes, how many weeks? _____

Tobacco Use
Cigarettes: ☐ Never ☐ Former Quit Date_____ ☐ Current Smoker: Packs/Day____ # of years____
Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use
Do you drink alcohol? ☐ No ☐ Yes # drinks/week_____
Type: ☐ Beer ☐ Wine ☐ Hard Liquor ☐ Mixed Drink
Is your alcohol use a concern for you or others? ☐ No ☐ Yes

Drug Use
Do you use any recreational drugs? ☐ No ☐ Yes
Have you ever used needles to inject drugs? ☐ No ☐ Yes
Have you used in last year: ☐ Marijuana ☐ Amphetamines (Meth, Speed) ☐ Cocaine ☐ Heroin
☐ Other Street Drugs: _____

Describe the condition/pain problem for which you are being seen:_____
_____
When did your condition start or when did you first notice your pain? _____
_____
When did you first see a doctor for your condition/pain? _____
Have you ever had a similar condition/pain before? ☐ No ☐ Yes-please describe _____
_____
Under what circumstance did your condition/pain begin?
☐ Following illness/surgery ☐ Reason unknown
☐ Accident/Injury (**not work related**) D.O.I._____
☐ Accident/Injury (**work related)** D.O.I_____ Claim #_____
Claims manager name/phone# _____
Describe in detail how your injury/accident occurred:_____
_____
_____

Since your pain began, has it: ☐ Increased ☐ Decreased ☐ Stayed the same

Typically, how long can you continuously: (select **ONE** answer only for each category)

SIT: ☐ Less than 15 minutes ☐ 15-30 minutes ☐ 31-45 minutes
☐ 45-60 minutes ☐ 1-2 hours ☐ More than 2 hours

STAND: ☐ Less than 15 minutes ☐ 15-30 minutes ☐ 31-45 minutes
☐ 45-60 minutes ☐ 1-2 hours ☐ More than 2 hours

WALK: ☐ Less than 15 minutes ☐ 15-30 minutes ☐ 31-45 minutes
☐ 45-60 minutes ☐ 1-2 hours ☐ More than 2 hours

Circle the appropriate number on the following scales

Your pain at its **WORST**

No Pain ☐ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
☐ Unbearable Pain

Your pain at its **LEAST** severe

No Pain ☐ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
☐ Unbearable Pain

Your pain as it **USUALLY** is

No Pain ☐ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
☐ Unbearable Pain

Your pain at the **PRESENT** time

No Pain ☐ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
☐ Unbearable Pain

What time of day is your pain the worst?

☐ Morning, on arising ☐ Later in the morning ☐ Afternoon ☐ Evening
☐ Bedtime ☐ Night (during usual sleeping hours)
☐ Pain is always the same ☐ Pain varies, not worse at any particular time

Which statement best describes your pain?

☐ Always present, always the same intensity
☐ Always present, intensity varies
☐ Usually present-short periods without pain
☐ Often present-but have pain-free periods lasting one to several hours
☐ Occasionally present-but am pain-free for most of the day
☐ Occasionally present for brief periods, a few seconds to a few minutes
☐ Rarely present-have pain every few days or weeks

Would you describe your pain as (Select all that apply)

☐ Burning ☐ Aching ☐ Throbbing ☐ Shooting ☐ Electrical
☐ Sharp ☐ Tight ☐ Pulling ☐ Stabbing
☐ Other_____

Do you have (Select all that apply)

☐ Numbness ☐ Weakness ☐ Coldness
☐ Increased sensitivity to touch ☐ Tingling, pins and needles ☐ Increased sweating
☐ Muscle spasms, tightness ☐ Skin color changes ☐ Loss of bowel or bladder control

Do any of the following make your pain feel worse? (Select all that apply)

☐ Coughing, sneezing ☐ Walking ☐ Sitting ☐ Physical activity
☐ Standing ☐ Sexual activity ☐ Lying down ☐ Other_____

Do any of the following make your pain feel better? (Select all that apply)

☐ Relaxation ☐ Walking ☐ Sitting ☐ Physical activity ☐ Standing
☐ Sexual activity ☐ Lying down ☐ Alcoholic drinks ☐ Heat ☐ Medicines
☐ Cold ☐ Other_____ ☐ Nothing makes me feel better

Does pain interrupt your sleep?

☐ Not at all ☐ Once per night ☐ Twice per night
☐ Three times per night ☐ More than three times per night

Have you had nerve blocks/ injections for pain relief? ☐ No ☐ Yes, who was the doctor:_____
When was your last block?_____
How did the blocks affect your pain? ☐ Made the pain worse
☐ No change ☐ Better for a while How long? _____

Check what non-drug therapies you have tried for relief of pain:

Physical Therapy	☐ Helped	☐ Did not help
Massage Therapy	☐ Helped	☐ Did not help
Chiropractic Treatment	☐ Helped	☐ Did not help
Acupuncture	☐ Helped	☐ Did not help
Hot/Cold Therapy	☐ Helped	☐ Did not help
NSAID's (Aspirin, Ibuprofen, Naproxen)	☐ Helped	☐ Did not help
Biofeedback	☐ Helped	☐ Did not help
T.E.N.S (Electrical Stimulation)	☐ Helped	☐ Did not help
Bed Rest	☐ Helped	☐ Did not help
Traction	☐ Helped	☐ Did not help
Osteopathic Treatment	☐ Helped	☐ Did not help
Psychotherapy /Counseling	☐ Helped	☐ Did not help
Other:_____	☐ Helped	☐ Did not help

Leaning **FORWARD** makes my pain: ☐ better ☐ worse ☐ no change ☐ not sure

Leaning **BACKWARD** make my pain: ☐ better ☐ worse ☐ no change ☐ not sure

Does your pain travel anywhere? ☐ no ☐ yes Where? _____

Please Check all that apply

CONSTITUTION
- ☐ Activity Change
- ☐ Appetite Change
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Unexpected Weight Change

HENT
- ☐ Neck Pain
- ☐ Hearing Loss
- ☐ Tinnitus
- ☐ Sinus Pressure
- ☐ Dental Problems
- ☐ Drooling
- ☐ Mouth Sores
- ☐ Trouble Swallowing
- ☐ Voice Change

EYES
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Photophobia
- ☐ Visual Disturbance

RESPIRATORY
- ☐ Cough
- ☐ Shortness of Breath

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Palpitations

GI
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

GENITOURINARY
- ☐ Difficulty Urinating
- ☐ Dysuria
- ☐ Frequency

MUSCULOSKELETAL
- ☐ Arthralgia's (Joint Pain)
- ☐ Back Pain
- ☐ Gait Problem
- ☐ Joint Swelling
- ☐ Myalgia's (Muscle Pain)

SKIN
- ☐ Rash

NEUROLOGICAL
- ☐ Dizziness
- ☐ Facial Asymmetry
- ☐ Headaches
- ☐ Light-headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech Difficulty
- ☐ Syncope (Fainting)
- ☐ Tremors
- ☐ Weakness

HEMATOLOGIC
- ☐ Bruises/Bleeds Easily

PSYCHIATRIC
- ☐ Agitation
- ☐ Confusion / Memory Loss
- ☐ Decreased Concentration
- ☐ Dysphonic (Changing)
- ☐ Mood / Depression
- ☐ Hallucinations
- ☐ Nervous/Anxious
- ☐ Sleep Disturbance

Indicate your areas of pain by shading on this diagram.