



THE UNIVERSITY OF TOLEDO
MEDICAL CENTER

**Physical Medicine and Rehabilitation
Clinic**
Dr. Amish R. Patel DO, MPH
Pain and Medical History

Patient Label

PLEASE COMPLETE AND BRING TO YOUR APPOINTMENT.

Patient Name: _____ Appointment Date: _____

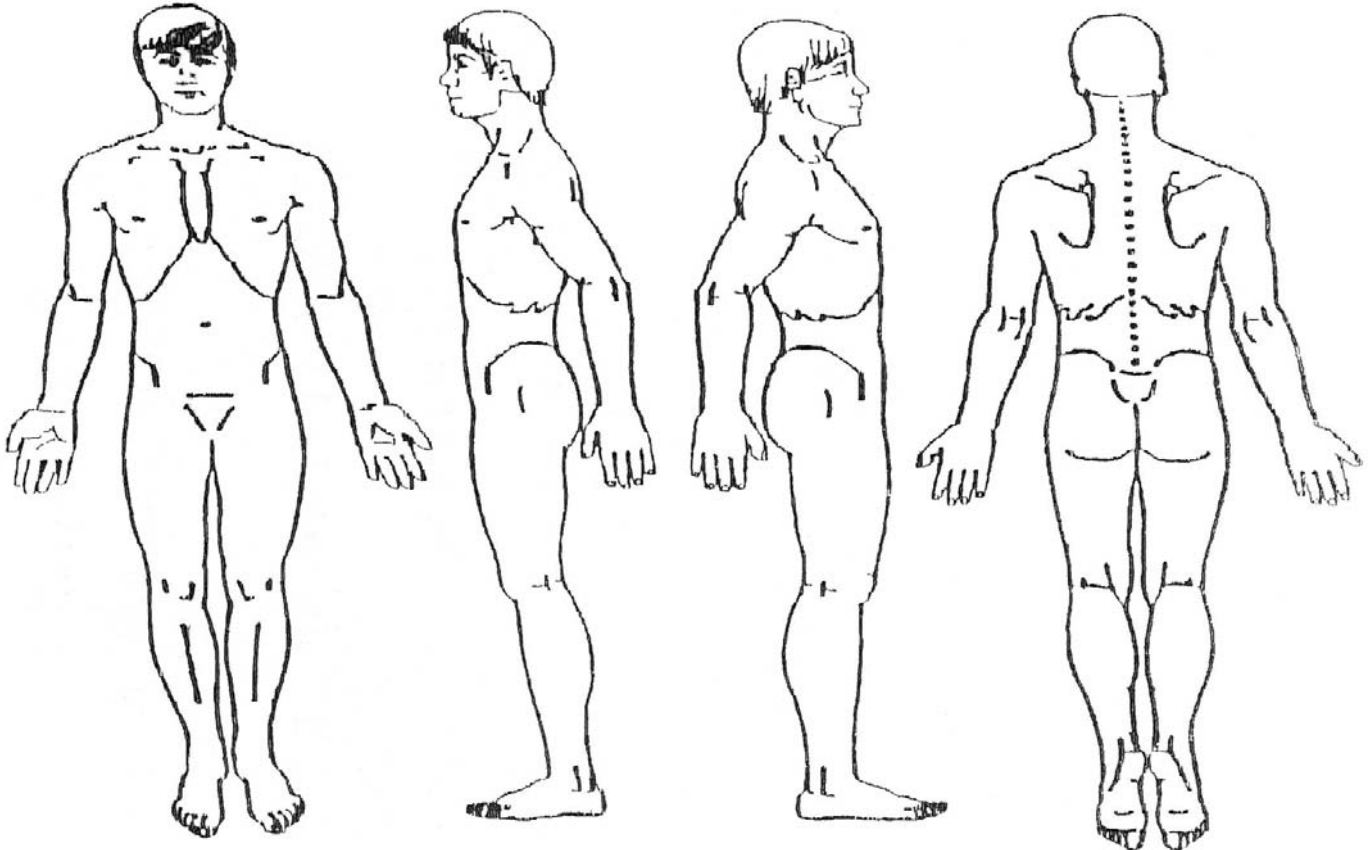
Referring Physician: _____ Family Physician: _____

INSTRUCTIONS:

Draw the location of your pain on the body outlines & mark how severe it is on the pain line at the bottom of the page.

KEY:

Aching	Burning	Numbness	Pins & Needles	Stabbing	Other
ΛΛΛΛΛ	→→→→→	00000	●●●●●	/////	XXXXX
ΛΛΛΛΛ	→→→→→	00000	●●●●●	/////	XXXXX



(Check the worst & best it's been and circle your current pain level)

0	No Pain
1	Mild pain; you are aware of it, but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain; It may make you contemplate suicide





8. Which of the following increase your pain to the level mentioned in the preceding set of questions?
- | | | | |
|-------------------------------------------------------------|-------------------------------------------------|---------------------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Lift objects | <input type="checkbox"/> Bend forward | <input type="checkbox"/> Bend backward | <input type="checkbox"/> Bend to the right |
| <input type="checkbox"/> Bend to the left | <input type="checkbox"/> Lie on your back | <input type="checkbox"/> Lie on your stomach | |
| <input type="checkbox"/> Lie on right side | <input type="checkbox"/> Lie on left side | <input type="checkbox"/> Look up | <input type="checkbox"/> Look down |
| <input type="checkbox"/> Turn head to the left | <input type="checkbox"/> Turn head to the right | | |
| <input type="checkbox"/> Move left ear toward left shoulder | | <input type="checkbox"/> Move right ear toward right shoulder | |
| <input type="checkbox"/> In the morning | <input type="checkbox"/> In the afternoon | <input type="checkbox"/> In the evening | |
9. Which of the following decrease your pain level?
- | | | | |
|-------------------------------------------------------------|-------------------------------------------------|---------------------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Lift objects | <input type="checkbox"/> Bend forward | <input type="checkbox"/> Bend backward | <input type="checkbox"/> Bend to the right |
| <input type="checkbox"/> Bend to the left | <input type="checkbox"/> Lie on your back | <input type="checkbox"/> Lie on your stomach | |
| <input type="checkbox"/> Lie on right side | <input type="checkbox"/> Lie on left side | <input type="checkbox"/> Look up | <input type="checkbox"/> Look down |
| <input type="checkbox"/> Turn head to the left | <input type="checkbox"/> Turn head to the right | | |
| <input type="checkbox"/> Move left ear toward left shoulder | | <input type="checkbox"/> Move right ear toward right shoulder | |
| <input type="checkbox"/> In the morning | <input type="checkbox"/> In the afternoon | <input type="checkbox"/> In the evening | |
10. Select if you have any of the associated signs and symptoms?
- | | | | |
|------------------------------------------------------|--------------------------------------|--------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Bowel incontinence | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Increased pain at nighttime | <input type="checkbox"/> Fever | <input type="checkbox"/> Chills | <input type="checkbox"/> Night sweats |
11. Please answer the following questions using the following scale:
- | | |
|--------------------------|----------------------|
| 1: unable to tolerate | 5: about ½ hour only |
| 2: several minutes only | 6: about 1 hour |
| 3: about 10 minutes only | 7: several hours |
| 4: about 20 minutes only | 8: indefinite period |
- a. How long can you sit
b. How long can you stand
c. How long can you walk
d. Any history of falls? Yes No
e. History of Physical, Emotional and/or Sexual abuse Yes No
f. If yes did you seek counseling or any form of treatment Yes No
12. Patient History
- | | | |
|---------------------------------------------------------|----------------------------------------------------------|---------------------|
| a. Did you have physical therapy for at least 6 weeks | <input type="checkbox"/> Yes <input type="checkbox"/> No | Month_____Year_____ |
| b. Did physical therapy provide you with 80% relief | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| c. Did you try anti-inflammatory medications | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| d. Did you try this type of medication at least 6 weeks | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
13. Which physicians have you seen for treatment of your current pain? Please list in chronological order and describe what was done.
-
-
-
-
-
-
-
-
-
-



14. Review of Systems: Check ones that apply to you

- | | | | | |
|------------------------|-------------------------------------------------------|----------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------|
| Constitutional: | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Fever |
| | <input type="checkbox"/> Chills | <input type="checkbox"/> Night sweats | | |
| Head and Neck: | <input type="checkbox"/> Headache | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Limited neck motion |
| Eyes: | <input type="checkbox"/> Change in vision | <input type="checkbox"/> Vision loss | <input type="checkbox"/> Glasses | <input type="checkbox"/> Contacts |
| Ears: | <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Ringing in the ears | | |
| Nose: | <input type="checkbox"/> Change in smell | <input type="checkbox"/> Snoring | | |
| Mouth and Throat: | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Change in taste | <input type="checkbox"/> Voice change | <input type="checkbox"/> Difficulty swallowing |
| Cardiovascular: | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Light headedness | |
| Respiratory: | <input type="checkbox"/> Shortness of breath | | <input type="checkbox"/> Cough | <input type="checkbox"/> TB exposure |
| Gastrointestinal: | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Heart burn | <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Rectal bleeding |
| Skin: | <input type="checkbox"/> Lesions | <input type="checkbox"/> Easy bleeding | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Bowel incontinence |
| Genito-Urinary: | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Problems urinating | | |
| Female: | <input type="checkbox"/> Last menstrual period: _____ | | | Any chance of pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Musculoskeletal: | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Bone pain | | |
| Neurologic: | <input type="checkbox"/> Numbness | <input type="checkbox"/> Weakness | <input type="checkbox"/> Unsteady walking | |
| Psychiatric: | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | | |
| Endocrine: | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Osteoporosis | |
| Hematologic/Lymphatic: | <input type="checkbox"/> Slow healing after cuts | | <input type="checkbox"/> Easy bleeding and bruising | |

15. Past Medical History: Please list all of your major illnesses or diseases

16. Past Surgical History: Please list all of your surgeries.

17. Past Family History:

- a. Does your mother have history of cancer? Yes No If yes indicate what type.

- b. Is your mother alive or deceased? Please indicate her age. _____
- c. Does your father have history of cancer? Yes No If yes indicate what type.

- d. Is your father alive or deceased? Please indicate his age. _____

18. Personal and Social History:

- a. Marital Status: Single Married Widow Other
- b. Alcohol use: None Yes Amount: _____
- c. Drug abuse: None Yes Type: _____
- d. Smoking: None Yes Amount: _____

19. Allergies:

1. Medications: _____
2. Shrimp: Yes No
3. Shellfish: Yes No
4. Iodine: Yes No
5. Contrast dye: Yes No

20. Current Medications and dosages (please bring an updated list to each visit, including dose and how taken)



21. **Pharmacy Name and Number:** _____

22. **Work History:**

a. Is this a workers compensation claim? Yes No
If yes, Date of injury _____ claim number _____
Occupation at time of injury: _____
Do you have work FMLA leave? (Family Medical Leave Act)
Leave start date _____ Leave end date _____
 Full time Intermittent

b. Which statements describe your current employment situation? (Check all that apply)

1. Currently working, occupation _____
2. Are you self employed Yes No
3. On paid leave
4. Unemployed
5. Homemaker
6. Student
7. Retired
8. Disabled and/or retired because of my back pain
9. Disabled due to health problem not related to my back
10. Other, please specify: _____

c. How many jobs have you had in the last 3 years? _____

d. If you are not working who put you off work? _____

e. What are your current work restrictions?

f. Provide the date you last went to work. _____

g. Is your current job the same one you had when your current pain symptoms started?

1. yes, exact same job
2. Yes, but job was modified or hours reduced because of my back
3. No, I have changed jobs because of my back symptoms
4. No, I have changed jobs but for reasons unrelated to my back
5. Not working now

h. How long have you worked at your current job?

1. Less than six months
2. Six to twelve months
3. More than twelve months
4. Not working now

i. Please answer each of the following questions about your current job (or the one you plan to go back to if on leave). Check one answer on each line.

	Less than 1 hour	1 to 2 hours	3 to 4 hours	5 to 6 hours	7 to 8 hours	Greater than 8 hours
How much sitting does your work involve?	1	2	3	4	5	6
How much standing or walking does your work involve?	1	2	3	4	5	6
How often do you lift 25 pounds on the job?	1	2	3	4	5	6
How often do you lift 50 pounds on the job?	1	2	3	4	5	6
How much pushing or pulling on the job?	1	2	3	4	5	6
How much bending on the job?	1	2	3	4	5	6



j. Please answer each of the following questions about your current job (or one you plan to go back to if on leave).

	Extremely	Very much	Quite a bit	Some-what	A little	Not at all
Is your current work physically demanding?						
Is your work stressful to you?						
How much do you like your job?						
How much do you like your co-workers?						
How much do you like your supervisor?						

k. Other than your salary, what other source of income does your household receive?

1. Another person's salary
2. State support
3. Social Security
4. Disability
5. Other (investments, retirement plan, etc.)
6. No other source of income

l. Are you experiencing financial difficulties because of your pain?

1. None at all
2. Only a little
3. Some
4. A lot

Are you on or planning to apply for any of the following programs?	Already on it	Applied for it	Planning to apply for it
Social Security	1	2	3
Disability	1	2	3
Workers Compensation	1	2	3
Other	1	2	3

NONE OF THE ABOVE APPLIES

23. Do you think the fault for your current back condition is? (Check all that apply)

- Yours Your employer's A co-worker's Another person's Nobody's

24. Have you hired a lawyer because of your back condition?

- No, I have not hired a lawyer
 Yes, I have and the case is in litigation
 Yes, I have and the case has been settled

25. What is the name of your lawyer and phone number? _____

26. May we leave a voice message if we need to reach you? Yes No

If yes, Phone number(s) _____

Patient Signature _____ Date/Time _____

Reviewed by _____ Date/Time _____