ECU HEALTH

ECU Health Pain Management Center–Greenville
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Greenville NC 27834
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NEW PATIENT EVALUATION

Date: _____

Patient Name: _____ _____
First MI Last Date of Birth

Who referred you: _____

Primary Care Physician: _____

Pharmacy name and telephone number: _____

Have you been seen at any other pain clinics? ☐ Yes ☐ No Where? _____

When? _____ Have you ever signed an opioid agreement? ☐ Yes ☐ No

1. If you are a Female, please tell us your pregnancy status:
   ☐ Hysterectomy ☐ Post-Menopausal ☐ No Contraception Birth ☐ Birth Control Medication
   ☐ Other Contraception

2. When did your pain first begin, month and year: _____

3. What is the main cause of your pain?
   ☐ Unknown ☐ Normal Aging ☐ Fall ☐ Sporting Accident
   ☐ Motor Vehicle Accident ☐ Work Injury

4. What is the frequency of your pain?
   ☐ Constant ☐ Fluctuating, but always present ☐ Fluctuating, but usually present ☐ Fluctuating, but rarely present

5. What best describes your pain? Choose one or more:
   ☐ Aching ☐ Burning ☐ Cramping ☐ Dull
   ☐ Numb ☐ Sharp ☐ Stabbing ☐ Stinging
   ☐ Throbbing ☐ Tingling

6. What is your pain level most of the time:
   ☐ 0-No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10-Severe Pain

7. What makes your pain worse? Choose one or more:
   ☐ Nothing ☐ From sitting to standing ☐ Lying on side ☐ Lifting or carrying heavy loads
   ☐ Bending or stooping ☐ Sitting ☐ Lying on back ☐ Lifting or carrying small loads
   ☐ Standing ☐ Walking

Patient Name: _____ DOB: _____

8. What makes your pain better? Choose one or more:

☐ Lying on side ☐ Lying on back ☐ Sitting ☐ Standing
☐ Walking ☐ Stretching ☐ Exercise ☐ Nothing

9. What does your pain interfere with? Choose on or more:

☐ Daily Chores ☐ Employment ☐ Exercise ☐ Grooming
☐ House Chores ☐ Mood ☐ Sleep ☐ Relationships
☐ Walking ☐ Nothing

10. Have you had any of the following Imaging/Tests to assist in the evaluation of your pain:

MRI ☐ Yes ☐ No CT-Scan ☐ Yes ☐ No Xray ☐ Yes ☐ No EMG/Nerve Study ☐ Yes ☐ No

11. Have you had any of the following to assist in the evaluation of your pain? Choose one or more:

☐ Blood work related to pain syndrome ☐ Bone Scan ☐ Vascular Studies
☐ Drug Screening ☐ Bone Density ☐ Functional Capacity Exam
☐ Depression Screening

12. Have you had any of the following injections to assist with the treatment of your pain? Choose one or more:

☐ Spinal ☐ Joint ☐ Muscle ☐ None

13. Have you received any of the following related to your pain:

☐ Back Brace ☐ Neck Brace ☐ Tens Unit ☐ None

14. Have you had any of the following surgeries:

☐ Low Back ☐ Mid Back ☐ Neck ☐ Hip
☐ Knee ☐ Shoulder ☐ None

15. Have you tried any of the following therapies:

☐ Physical ☐ Chiropractic ☐ Aqua ☐ None
Date _____ Date _____ Date _____
Location _____ Location _____ Location _____

16. Have you had any of the following to assist you with your pain:

☐ Spinal Cord Stimulation ☐ Spinal Traction ☐ Cane ☐ Walker
☐ Exercise ☐ Weight Loss ☐ Intrathecal Pain Pump ☐ None

17. Have you tried any of the Anti Inflammatory Medications below: ☐ None Tried

Aspirin:	☐ Helpful	☐ Not Helpful	Indomethacin:	☐ Helpful	☐ Not Helpful
Celebrex®:	☐ Helpful	☐ Not Helpful	Ketroprofen:	☐ Helpful	☐ Not Helpful
Diclofenac:	☐ Helpful	☐ Not Helpful	Mobic®:	☐ Helpful	☐ Not Helpful
Daypro®:	☐ Helpful	☐ Not Helpful	Naproxen:	☐ Helpful	☐ Not Helpful
Duexis®:	☐ Helpful	☐ Not Helpful	Relafen®:	☐ Helpful	☐ Not Helpful
Etodalac:	☐ Helpful	☐ Not Helpful	Toradol®:	☐ Helpful	☐ Not Helpful
Prednisone:	☐ Helpful	☐ Not Helpful	Tylenol®:	☐ Helpful	☐ Not Helpful

Patient Name: _____ DOB: _____

18. Have you tried any of the muscle relaxer medications below: ☐ None tried

Baclofen:	☐ Helpful	☐ Not Helpful		Norflex™:	☐ Helpful	☐ Not Helpful	
Cyclobenzaprine:	☐ Helpful	☐ Not Helpful		Parafon®:	☐ Helpful	☐ Not Helpful	
Carisoprodol:	☐ Helpful	☐ Not Helpful		Skelaxin®:	☐ Helpful	☐ Not Helpful	
Diazepam:	☐ Helpful	☐ Not Helpful		Tizanidine:	☐ Helpful	☐ Not Helpful	
Methocarbamol:	☐ Helpful	☐ Not Helpful					

19. Have you tried any of the narcotic medications below: ☐ None tried

Avinza:	☐ Helpful	☐ Not Helpful		Oxycontin®:	☐ Helpful	☐ Not Helpful	
Codeine:	☐ Helpful	☐ Not Helpful		Oxycodone:	☐ Helpful	☐ Not Helpful	
Duragesic®:	☐ Helpful	☐ Not Helpful		MS IR®:	☐ Helpful	☐ Not Helpful	
Dilaudid®:	☐ Helpful	☐ Not Helpful		Methadone:	☐ Helpful	☐ Not Helpful	
Hydrocodone:	☐ Helpful	☐ Not Helpful		Morphine ER:	☐ Helpful	☐ Not Helpful	
Kadian®:	☐ Helpful	☐ Not Helpful		Tramadol:	☐ Helpful	☐ Not Helpful	
Opana®:	☐ Helpful	☐ Not Helpful					

20. Have you tried any of the following "other" medications below: ☐ None tried

Cymbalta®:	☐ Helpful	☐ Not Helpful		Lyrica®:	☐ Helpful	☐ Not Helpful	
Clonidine:	☐ Helpful	☐ Not Helpful		Neurontin®:	☐ Helpful	☐ Not Helpful	
Elavil®:	☐ Helpful	☐ Not Helpful		Savella®:	☐ Helpful	☐ Not Helpful	
Keppra®:	☐ Helpful	☐ Not Helpful		Topamax®:	☐ Helpful	☐ Not Helpful	
Klonopin®:	☐ Helpful	☐ Not Helpful		Trileptal®:	☐ Helpful	☐ Not Helpful	
Lidoderm Patch®:	☐ Helpful	☐ Not Helpful		Zonegran®:	☐ Helpful	☐ Not Helpful	
Horizant®:	☐ Helpful	☐ Not Helpful		Requip™:	☐ Helpful	☐ Not Helpful	

21. Have you tried any Over-the-Counter Medications such as BioFreeze® or IcyHot®? ☐ Yes ☐ No

22. Have you tried any prescription creams such as EMLA Cream™ or Voltaren Gel®? ☐ Yes ☐ No

23. Have you tried a compound pain cream or scar cream? ☐ Yes ☐ No

24. Allergies: ☐ Yes ☐ No

List Allergies: _____

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25. Past Medical History (check all that apply):

☐ Migraine headaches	☐ High blood pressure	☐ Emphysema	☐ Cirrhosis
☐ Kidney disorder	☐ Cancer	☐ Head Injury	☐ High cholesterol
☐ Asthma	☐ Hepatitis	☐ Fibromyalgia	☐ Depression
☐ Stroke	☐ Coronary artery disease	☐ Sleep Apnea	☐ Gallbladder disease
☐ Osteoporosis	☐ Anxiety	☐ Seizures	☐ Heart Attack
☐ Hiatal Hernia	☐ Pancreatitis	☐ Spine Disorder	☐ Alcoholism
☐ Addiction	☐ Reflux	☐ Multiple Sclerosis	☐ Heart Arrhythmia
☐ Diabetes	☐ Arthritis OA/RA	☐ Peripheral Nerve disease	☐ HIV
☐ Ulcers	☐ Bowel Disease	☐ Muscle disorder	

26. Past Surgical History: _____

_____

_____

27. Family Medical History (check all that apply):

☐ Migraine headaches	☐ High blood pressure	☐ Emphysema	☐ Cirrhosis
☐ Kidney disorder	☐ Cancer	☐ Head Injury	☐ High cholesterol
☐ Asthma	☐ Hepatitis	☐ Fibromyalgia	☐ Depression
☐ Stroke	☐ Coronary artery disease	☐ Sleep Apnea	☐ Gallbladder disease
☐ Osteoporosis	☐ Anxiety	☐ Seizures	☐ Heart Attack
☐ Hiatal Hernia	☐ Pancreatitis	☐ Spine Disorder	☐ Alcoholism
☐ Addiction	☐ Reflux	☐ Multiple Sclerosis	☐ Heart Arrhythmia
☐ Diabetes	☐ Arthritis OA/RA	☐ Peripheral Nerve disease	☐ Ulcers
☐ Bowel Disease	☐ Muscle disorder		

28. What is your marital status:

☐ Sing ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

29. Who resides in your home and/or assists you if needed:

☐ Alone ☐ Spouse ☐ Children ☐ Parents

☐ Skilled Nursing Facility/Hospice House, what is the name of it: _____

30. Smoking Status:

☐ Every day smoker ☐ Occasional smoker ☐ Former smoker ☐ Non-smoker

31. Alcohol Use:

☐ None ☐ Rarely ☐ Occasionally ☐ Regularly

32. Do you use street drugs:

☐ Yes ☐ No

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33. Preventative Medicine: Falls Risk Screening: **IF YOU ARE 65 OR OLDER PLEASE CHECK ALL THAT APPLY**

- ☐ No falls in the past year
- ☐ One fall with injury in the past year
- ☐ One fall without injury in the past year
- ☐ Two or more falls with injury in the past year
- ☐ Two or more falls without injury in the past year

34. Review of systems (Mark all that apply):

General
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Night sweats
- ☐ Fatigue
- ☐ Many infections

HEENT
- ☐ Headache
- ☐ Facial pain
- ☐ Sinusitis
- ☐ Loss of vision
- ☐ Hearing loss
- ☐ Teeth/Gum problems

Respiratory
- ☐ Chronic cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Sleep Apnea
- ☐ Home oxygen use
- ☐ C-Pap

Cardiology
- ☐ Chest pain
- ☐ Murmur
- ☐ Congestive failure
- ☐ Abnormal EKG
- ☐ High Blood Pressure

GI
- ☐ Appetite loss
- ☐ Chronic Anemia
- ☐ Heartburn
- ☐ Constipation
- ☐ Testicular pain
- ☐ Diarrhea

Genitourinary
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Bladder control loss
- ☐ Enlarged prostate

Endocrine/Hemat
- ☐ Abnormal blood sugars
- ☐ Easy bruising/bleeding
- ☐ Dizziness
- ☐ Thyroid Problems

Musculosketal
- ☐ Joint pain
- ☐ Muscle spasm
- ☐ Neck pain
- ☐ Back pain
- ☐ Carpel Tunnel
- ☐ Gout
- ☐ Swollen Joints

Neurology
- ☐ Drowsiness
- ☐ Dizziness
- ☐ Blackouts
- ☐ Tremors
- ☐ Numbness
- ☐ Memory Loss
- ☐ Balance Difficulty

Psychiatric
- ☐ Panic Attack/Anxiety
- ☐ Insomnia
- ☐ Depression

Vascular
- ☐ Poor circulation
- ☐ Current blood clot
- ☐ Swelling in legs

Skin
- ☐ Rash

35. List all medications you are currently taking: _____

_____

_____

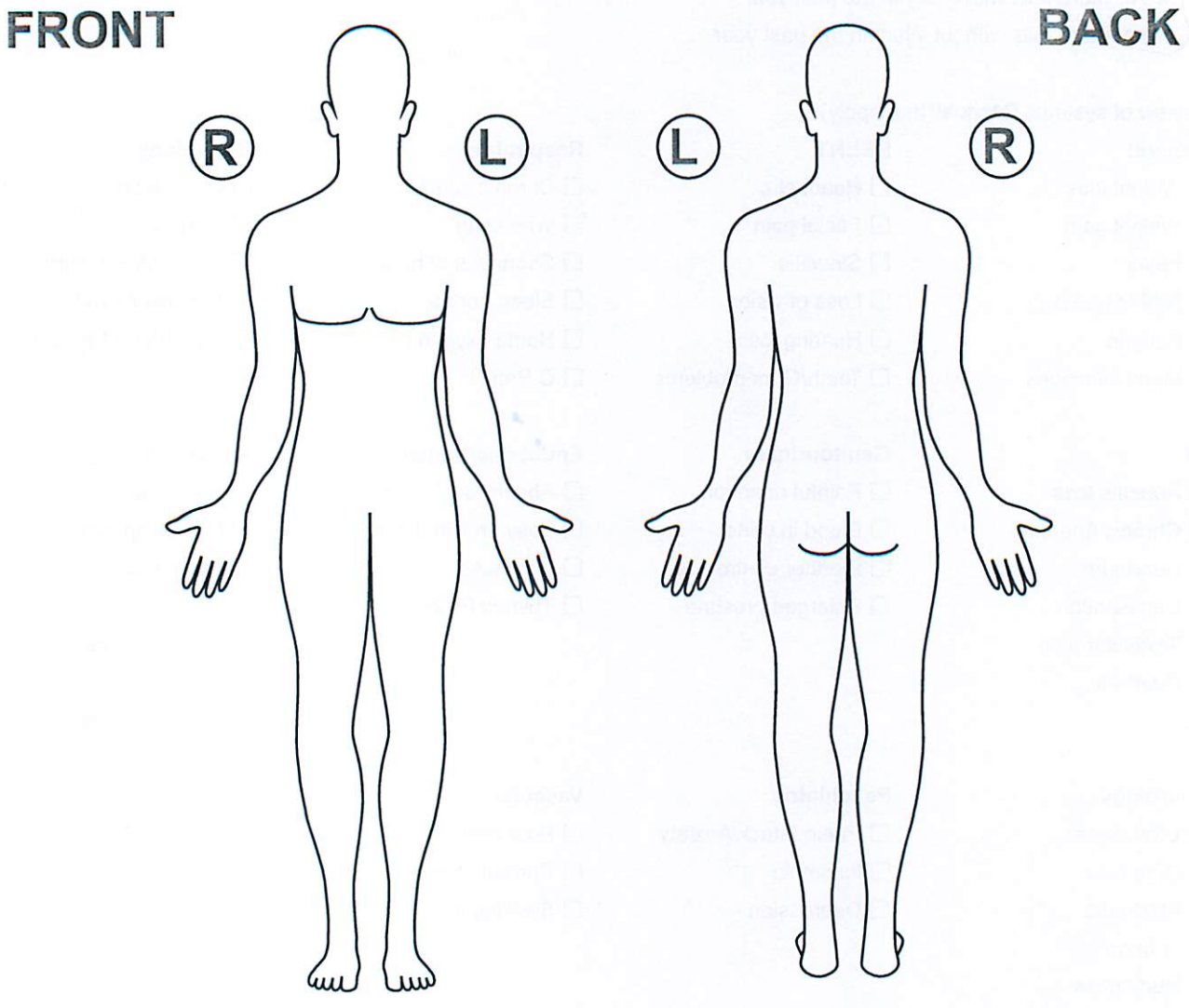
_____

_____

_____

_____

On the diagram below, shade in the areas where you feel pain. Put an 'X' on the area that hurts the most. Draw a line if the pain moves from one area to another area.



ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 252-561-8218.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 252-561-8218.