Raritan Valley Pain Medicine Associates

"Taking strides in increasing YOUR quality of life."

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name: _____ **Date Of Birth:** _____

Home Address:_____ **Social Security Number:**_____

_____ **Patient Sex:** ☐M ☐F

Email:_____ **Phone #:**_____

Cell #:_____ **Marital Status:**_____

Employer:_____ **Work#:**_____

Reason for Visit: _____

Previous/ Referring Doctor: _____**Doctor's Phone #:** _____

Preferred Pharmacy Name/Location: _____ **Pharmacy Phone#:** _____

How did you hear about us? _____ **Social Security #** _____

Emergency Contact Name/ Phone#: _____ **Relationship:** _____

Race: □Native American □Asian □Black □White □Other □Refuse to Answer

Have you ever been discharged from a pain practice?

☐Yes ☐No

If so, why?_____

Ethnicity: □Hispanic □Non-Hispanic □Refuse to Answer

Preferred Language: □English □Spanish □Other

Primary Insurance

Payer: _____ **Plan:** _____

Policy/ID #: _____ **Group Number:** _____

***Insurance Policy Holder:** □Self □Spouse □Child □Other: _____ **Social Security #:** _____

Policy Holder Name: _____**Date of Birth:** _____

Secondary Insurance

Payer: _____ **Plan:** _____

Policy/ID #: _____ **Group Number:** _____

***Insurance Policy Holder:** □Self □Spouse □Child □Other: _____ **Social Security #:** _____

Policy Holder Name: _____**Date of Birth:** _____

Workers Compensation Claim Information

Workers Comp Company:_____**Adjuster Name:** _____

Adjuster Phone #:_____**Phone #:** _____ **Fax #:** _____

Claim #: _____ **Date of Injury:**_____

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PATIENT NAME: _____DOB: _____

HEALTH HABITS AND PERSONAL SAFETY (SOCIAL HISTORY)

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise
☐ Sedentary (No exercise) ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet
Are you dieting? ☐ Yes ☐ No
If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No
# of meals you eat in an average day?

Caffeine
☐ None ☐ Coffee ☐ Tea ☐ Cola
# of cups/cans per day?

Alcohol
Do you drink alcohol? _____ ☐ Yes ☐ No
If yes, what kind? _____
How many drinks per week? _____

Tobacco
Do you use tobacco? ☐ Yes ☐ No
☐ Cigarettes – packs/day _____ ☐ Chew - #/day_____ ☐ Pipe - #/day _____ ☐ Cigars - #/day _____
☐ # of years_____ ☐ **Or year quit_____**

Drugs
Do you currently use recreational or street drugs? ☐ Yes ☐ No If so, what drug? _____
Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

Personal Safety

Do you live alone?	☐ Yes	☐ No
Do you have frequent falls?	☐ Yes	☐ No
Do you have vision or hearing loss?	☐ Yes	☐ No
Physical and/or mental abuse has become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your doctor or his staff?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

Relation	Age	Health Problems	Age at Death
Father			
Mother			
Brothers			
Sisters			

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

Allergies to Medications? ? □No □Yes → If so, then to what?

Current Medications: (Name/Dose/ Frequency)

1.	**7.**
2.	**8.**
3.	**9.**
4.	**10.**
5.	**11.**
6.	**12.**

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PATIENT NAME: _____ **DOB:** _____

Review Of Systems (check all that apply to you)

CONSTITUTIONAL
- ☐ Weight loss or gain
- ☐ Fever
- ☐ Fatigue
- ☐ Chills

EYES
- ☐ Blurry vision
- ☐ Double vision
- ☐ Vision changes
- ☐ Cataracts
- ☐ Glaucoma

ENT/MOUTH
- ☐ Sinus problems
- ☐ Runny nose
- ☐ Tooth pain
- ☐ Hearing loss
- ☐ Ringing ears
- ☐ Gum pain
- ☐ Gum bleeding
- ☐ Swallowing difficulties
- ☐ Ear pain
- ☐ Ear discharge

ALLERGY/IMMUNO
- ☐ Rashes/hives/welts
- ☐ Itchiness
- ☐ Allergic asthma/bronchitis

NEURO
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Headache
- ☐ Lack of coordination
- ☐ Balance problems
- ☐ Seizures
- ☐ Numbness

PSYCH
- ☐ Depression
- ☐ Mood swings
- ☐ Memory problems
- ☐ Anxiety

ENDO
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Hair loss
- ☐ Nail changes
- ☐ Night sweats
- ☐ Hot flashes

SKIN
- ☐ Skin rashes
- ☐ Bruising
- ☐ Changes in skin lesions
- ☐ Wounds
- ☐ Ulcers

GENITOURINARY
- ☐ Burning urination
- ☐ Excessive urination
- ☐ Incontinence of urine
- ☐ Blood in urine
- ☐ Frequent bladder/kidney infections
- ☐ History of sexually transmitted disease

GASTROINTESTINAL
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Incontinence of bowels
- ☐ Blood in stools
- ☐ Bloating
- ☐ Poor appetite
- ☐ Hemorrhoids
- ☐ Nausea

HEM/LYMPH
- ☐ Bruising
- ☐ Nosebleeds
- ☐ Lack of energy

RESPIRATORY
- ☐ Frequent lung infections
- ☐ Shortness of breath
- ☐ Chest tightness
- ☐ Wheezing
- ☐ Sleeping problems
- ☐ Persistent cough
- ☐ Asthma

CARDIOVASCULAR
- ☐ History of Rheumatic fever
- ☐ Palpitations
- ☐ Chest pain
- ☐ Swelling hands
- ☐ Swelling feet
- ☐ Irregular heart beat
- ☐ High or low blood pressure

MUSC/SKELETAL
- ☐ Difficulty walking
- ☐ Joint stiffness
- ☐ Muscle pains
- ☐ Back pain
- ☐ Pain during walking

WOMEN ONLY

Age at menstruation: _____ Are you Pregnant? ☐ Yes ☐ No
Number of pregnancies _____ Number of live births _____
Date of or age at last menstruation: _____
Bone Density Screening: ☐ Normal ☐ Abnormal

MEN ONLY

Has the force of your urination decreased? ☐ Yes ☐ No
Date of last prostate and rectal exam? _____ ☐ Normal ☐ Abnormal
Date of last PSA test (if any): _____ ☐ Normal ☐ Abnormal

PERSONAL HEALTH HISTORY (PAST MEDICAL HISTORY)

Conditions you have had in the past (check all that apply):

□ AIDS/HIV+	□ Bulimia or Anorexia	□ Gout	□ Liver Disease	□ Stroke
□ Alcoholism	□ Cancer	□ Headaches	□ Migraines	□ Suicide Attempt
□ Amputation	□ Cataracts	□ Heart Disease	□ Mitral Valve Prolapse	□ Thyroid Problems
□ Anemia	□ Chemical Dependency	□ Heart Attack	□ Multiple Sclerosis	□ TB
□ Arthritis	□ Diabetes	□ Hepatitis	□ Murmur	□ Urinary Incontinence
□ Asthma	□ Dialysis	□ Herpes	□ Pacemaker/ Defibrillator	LIST ANY OTHERS
□ Bleeding Disorders	□ Emphysema/ COPD	□ High Blood Pressure	□ Paralysis	□
□ Breast Lump	□ Epilepsy	□ Incontinence (Bowel)	□ Poor Circulation	□
□ Bronchitis	□ Glaucoma	□ Kidney Disease	□ Seizures	□

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Date _____

Patient Name _____

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
		TOTAL	_____	_____

Total Score Risk Category
Low Risk 0 – 3
Moderate Risk 4 – 7
High Risk ≥8

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine.* 2005;6(6):432-442. Used with permission.

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Notification and Release of Medical and Financial Information

It is the policy of Raritan Valley Pain Medicine Associates not to release confidential information by home telephone, voicemail, cell phone and/or email without the patient's authorization. When contacting a patient, if the answering machine picks up, we will leave all necessary information pertaining to your appointment as well as request that you contact us back to confirm receipt. Information to a parent of a child under the age of 18 is allowed to be released under the HIPPA laws.

If you would like to have information released to someone other than yourself please complete the following:

I authorize the doctors and staff of Raritan Valley Pain Medicine Associates to leave medical and financial information pertaining to my care by the following methods and will assume responsibility to notify then whenever this information changes:

Home Telephone	_____ YES	_____ NO	# _____
Work Telephone	_____ YES	_____ NO	# _____
Cell Phone	_____ YES	_____ NO	# _____
E-mail	_____ YES	_____ NO	_____ @ _____

I authorize Raritan Valley Pain Medicine Associates to leave a voicemail when prompted

_____ YES _____ NO

You may discuss my personal health and financial information with the following person(s):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

In addition, I acknowledge receipt of the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Name of Patient or Personal Representative | Description of Personal representative's Authority

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Agreement and Assignment of Benefits

I have read and understand the financial policy of **Raritan Valley Pain Medicine Associates**, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to **Raritan Valley Pain Medicine Associates**. I understand that I am financially responsible for all services I receive from **Raritan Valley Pain Medicine Associates**. This financial policy is binding upon you and your estate, executors and/or administrators, if applicable.

Patient/Parent/Guardian or Legal Representative Signature Date

Patient/Parent/Guardian or Legal Representative (printed name)

Notice of Privacy Practices

I acknowledge that I have read and understand **Raritan Valley Pain Medicine Associates'** Notice of Privacy Practices, which is displayed for public inspection at our facility. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

Patient/Parent/Guardian or Legal Representative Signature Date

Patient/Parent/Guardian or Legal Representative (printed name)

Medical History and Consent for Treatment

I certify that all of the above information is accurate, complete and true.

I authorize **Raritan Valley Pain Medicine Associates**, any assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for **Raritan Valley Pain Medicine Associates** to retrieve and review my medication history. I understand that this will become part of my medical record.

I understand that the procedures and medications, which may be prescribed by **Raritan Valley Pain Medicine Associates**, can potentially have adverse effects on the status of one's fertility as well as a developing fetus. I will notify my pain management physician if there is any change in my fertility status or pregnancy status. Also, medications prescribed can potentially impair my ability to drive and operate machinery. I pledge to never drive impaired.

Patient/Parent/Guardian or Legal Representative Signature Date

Patient/Parent/Guardian or Legal Representative (printed name)