INTEGRITY PAIN MANAGEMENT CENTER

PATIENT INFORMATION

Please fill out the following information. This will make admission process quicker and will prevent answering the same questions repeatedly.

PLEASE PROVIDE THE MOST APPROPRIATE ANSWER

PATIENT NAME:_______________________________________

Religious Preference: ________________________

Language: _____________ **Are you able to read?** __________________ **Are you able to write?**___________________

Information obtained from: SELF OTHER (SPECIFY): ____

1. List all previous surgeries, major illnesses and or major injuries:

____
____
____

2. Have you or a member of your family ever had complications from an anesthetic: NO YES
Explain if yes,

____
____

3. Have you ever had any of the following illnesses?

PLEASE CHECK YES OR NO

	YES	NO		YES	NO
Angina (Chest Pain)	_____	_____	HIV Positive	_____	_____
Heart Attack	_____	_____	Kidney Problems	_____	_____
Stroke	_____	_____	High Blood Pressure	_____	_____
Asthma	_____	_____	Bleeding Problems	_____	_____
Emphysema	_____	_____	Head Injury	_____	_____
Tuberculosis	_____	_____	Muscle Weakness	_____	_____
Diabetes	_____	_____	Sleep Apnea	_____	_____
Hepatitis	_____	_____	Liver Damage	_____	_____
Vision Problems	_____	_____	Nerve Disease	_____	_____
Contacts	_____	_____	Seizures	_____	_____
Glasses	_____	_____	Dentures	_____	_____
Hearing Problems	_____	_____	Hearing Aids	_____	_____

Psychiatric History? If so, please explain:

____
____

List any other illnesses:

____
____

SUBSTANCE USE	HOW MUCH?	HOW LONG?	LAST USED?
Alcohol NO YES			
Drugs NO YES			
Tobacco NO YES			