ORTHOPAEDIC SURGERY SPECIALISTS
ossburbank.com

MEDICAL QUESTIONNAIRE

Pain Management & Regenerative Medicine

KINDLY USE BLACK INK

GENERAL

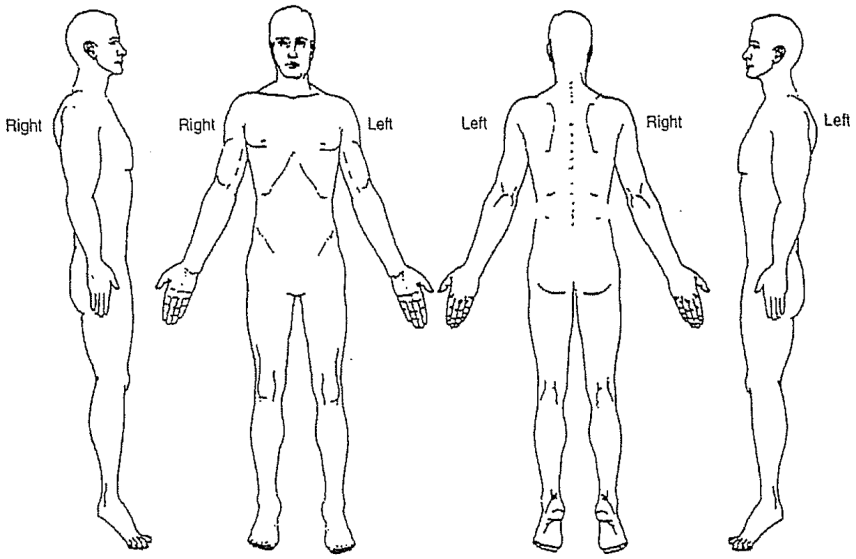
Patient Name *Last Name* *First Name* *M.I.*		Today's Date (MM/DD/YY)
Gender ☐ Male ☐ Female	Height	Weight

Which doctor referred you to OSS Pain Management & Regenerative Medicine?

PAIN: What is the current level of your pain?

Mark the drawing below **with an X** to show where you have the most severe pain.

Shade in the areas where you have less severe pain.



On a scale of 0 - 10 (0=no pain, 10=worst pain possible), what is your level of pain? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

How often do you have pain?

☐ Constantly ☐ Comes & Goes ☐ Certain Time of Day: ☐ With this Activity: _____

Have you been seen at a Pain Management Clinic before? ☐ No ☐ Yes

If yes, what was the the date(s), duration, and location / name of clinic? _____

How did your pain start?

☐ Work Injury ☐ Illness ☐ No Obvious Cause ☐ Injury, Not at Work ☐ Motor Vehicle or Motorcyle Accident ☐ Other: _____

How long have you had this pain? _____

How would you describe how your pain feels? _____

What makes your pain feel:

Better? _____

Worse? _____

How is your sleep? Describe. _____

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HISTORY OF TREATMENT: How have you tried to manage the pain?

Have you used any of these treatment(s) to ease your pain? Please check as it applies, provide the date(s), and describe outcome.

			Date(s) Tried	Outcome / Reason(s) Stopped?
Services				
Physical Therapy	☐ No	☐ Yes		
TENS Unit	☐ No	☐ Yes		
Aqua Therapy	☐ No	☐ Yes		
Acupuncture	☐ No	☐ Yes		
Biofeedback	☐ No	☐ Yes		
Spinal Cord Stimulation (SCS)	☐ No	☐ Yes		
Relaxation, imagery, mindfulness	☐ No	☐ Yes		
Injections				
Epidural Injection	☐ No	☐ Yes		
Transforaminal (Nerve Block) Injection	☐ No	☐ Yes		
Sacroiliac (SI) Joint Injection	☐ No	☐ Yes		
Facet Injection	☐ No	☐ Yes		
Trigger Point Injection	☐ No	☐ Yes		
Rhizotomy Injection	☐ No	☐ Yes		
Other	☐ No	☐ Yes		
Regenerative Medicine				
Platelet Rich Plasma (PRP)	☐ No	☐ Yes		
Stem Cell	☐ No	☐ Yes		
Prolotherapy	☐ No	☐ Yes		
Cartilage Regeneration	☐ No	☐ Yes		
Nonsteroidal Medications				
Motrin (Ibuprofen)	☐ No	☐ Yes		
Aleve	☐ No	☐ Yes		
Naproxen	☐ No	☐ Yes		
Mobic (Meloxicam)	☐ No	☐ Yes		
Lodine (Etodolac)	☐ No	☐ Yes		
Other				
Aspirin	☐ No	☐ Yes		
Tylenol	☐ No	☐ Yes		
Other	☐ No	☐ Yes		
Muscle Relaxants				
Baclofen	☐ No	☐ Yes		
Robaxin	☐ No	☐ Yes		
Zanaflex	☐ No	☐ Yes		
Skelaxin	☐ No	☐ Yes		
Flexeril	☐ No	☐ Yes		

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			Date(s) Tried	Outcome / Reason(s) Stopped?
Narcotics (Opiods)				
Codeine	☐ No	☐ Yes	_____	_____
Percocet	☐ No	☐ Yes	_____	_____
Oxycodone	☐ No	☐ Yes	_____	_____
Hydrocodone (Norco)	☐ No	☐ Yes	_____	_____
Opana (Oxymorphone)	☐ No	☐ Yes	_____	_____
Morphine	☐ No	☐ Yes	_____	_____
Oxycontin	☐ No	☐ Yes	_____	_____
Avinza	☐ No	☐ Yes	_____	_____
Hysingla	☐ No	☐ Yes	_____	_____
Duragesic (Fentanyl)	☐ No	☐ Yes	_____	_____
Suboxone	☐ No	☐ Yes	_____	_____
Neuromodulators				
Neurontin (Gabapentin)	☐ No	☐ Yes	_____	_____
Topamax	☐ No	☐ Yes	_____	_____
Lyrica	☐ No	☐ Yes	_____	_____
Cymbalta	☐ No	☐ Yes	_____	_____
Gabitril	☐ No	☐ Yes	_____	_____

What allergies do you have? _____

_____

SOCIAL HISTORY: What social factors should we consider in your care?

Have you ever used any of the following drugs? Check as it applies.

☐ Marijuana ☐ Heroin ☐ Suboxone ☐ Sedative / Downers ☐ Inhalants ☐ Amphetamines ☐ Cocaine ☐ Bath Salts

Please check your response. Scale: 1 = Never, 2 = Seldom, 3 = Sometimes, 4 = Often, 5 = Very Often

How often do you have mood swings?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How often do you smoke a cigarette within an hour of waking up?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How often have you taken medication other than the way it was prescribed?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How often have you used illegal drugs in the past five years?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How often in your lifeitme have you had legal problems or been arrested?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Comments: _____

Have you ever thought you should cut down on your drinking or drug use?	☐ No	☐ Yes
Have people ever annoyed you by criticising your drinking or drug use?	☐ No	☐ Yes
Have you ever had a drink or used drug in the morning to steady your nerves or get rid of a hangover?	☐ No	☐ Yes
Are you currently seeing a mental health provider or counselor?	☐ No	☐ Yes

AUTHORIZATION

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name (Print): _____

Patient Signature: _____ Date: _____