INTERVENTIONAL PAIN ASSOCIATES (IPA)

Name: _____ D.O.B: _____ Date: _____

What is your occupation? _____ What is your age? _____ When you were in the hospital last? Why? _____

Social History
___ Single
___ Widowed
___ Divorced
___ Separated
___ Married, how long? _____

Height: _____
Weight: _____

Are you diabetic? _____
How many years? _____
Do you take insulin? _____

Habits:
Smoke Yes No
Chew Tobacco Yes No
Alcohol Yes No
How Long? _____

Who is your family doctor? _____

Do you live alone? Yes No

Who do you live with? _____

Past Medical History & Years

Arthritis	Yes	No ____
Cancer	Yes	No ____
Diabetes	Yes	No ____
High Blood Pressure	Yes	No ____
Heart Disease	Yes	No ____
Heart Attack	Yes	No ____
Asthma	Yes	No ____
Emphysema	Yes	No ____
Lung Disease	Yes	No ____
Hypothyroidism	Yes	No ____
Stroke	Yes	No ____
High Cholesterol	Yes	No ____
Kidney Disease	Yes	No ____
Liver Disease	Yes	No ____
Other	Yes	No ____

Surgical History

Heart Bypass/Valve	Yes	No
Pacemaker	Yes	No
Carotid Neck Surgery	Yes	No
Gall Bladder	Yes	No
Hysterectomy	Yes	No
Appendectomy	Yes	No
Other (Please List)	Yes	No

_____

_____

_____

Medications

(If you have a list we will make a copy)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Medication Allergies

___ None Known ___ Penicillin
___ Sulfa ___ Codeine ___ Aspirin

Other (Please List) _____

_____

Medical History in detail:

_____
_____
_____

Trauma History: _____

_____

Family History (Write which family member)

Arthritis	Yes	No
Cancer	Yes	No
Diabetes	Yes	No
High Blood Pressure	Yes	No
Heart Disease	Yes	No
Lung Disease	Yes	No

Do you take any pain medicines? Yes No If so please list (include dosage): _____

_____

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