Ascension Borgess Allegan

PATIENT STICKER

Patient Name: _____Age: _____Sex: _____

Height: _____ Weight: _____

Forms Completed By: _____ Relation to Patient: _____

Past Medical History (List all medical conditions i.e Diabetes, Hypertension etc.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please List all **Surgeries** and date (month/year)

_____ month:_____year:_____ _____month:_____year:____

_____ month:_____year:_____ _____month:_____year:____

_____ month:_____year:_____ _____month:_____year:____

Family History: Please list health problems of immediate family members

Father: _____

Mother: _____

Siblings: _____

Any Family History of Substance Abuse? ☐ No ☐ Yes If yes, who? _____

Have you had any problems with anesthesia? ☐ No ☐ Yes If so, please explain: _____

Social History:

Marital Status: ☐ Single ☐ Married Occupation: _____ ☐ Disabled (How long?) _____ years

Tobacco: ☐ Never ☐ Current - Type_____ Qty: _____packs per day How long? _____ years

Current smokers only: I plan to quit: ☐ I'm not ready ☐ In the next 6 months ☐ In the next 30 days

Alcohol: ☐ Never ☐ Alcoholic beverages per week:_____ ☐ Recovering alcoholic How long? _____ years

Illicit drug usage: ☐ Never ☐ In the past ☐ Current drugs used: _____

Drug/alcohol abuse treatment: ☐ No ☐ Yes: ☐ Inpatient ☐ Outpatient Year: _____

Do you use marijuana? ☐ No ☐ Yes If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly

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Authorization for Prescription Pick-Up

I, _____ authorize the following person(s) to pick up my prescriptions for me.

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____

Signature of Patient: _____ Date: _____

**** Please Note: The person picking up the prescription will be required to sign their name and show picture identification. ****

Prescription Pick-up Document

Date	Print Name	Signature

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Instructions: Please complete all questions to the best of your ability. The Pain Management Center physician and staff will use this information to learn more about your pain history and prior treatments.

1. What caused the pain to begin? _____
2. When did it begin? _____
3. Did the pain begin gradually or suddenly? _____
4. Where did you go for initial treatment? _____
5. Please list the other doctors you have seen for *this condition*:

Doctor's Name	**Type of Doctor** (Neurologist, Neurosurgeon, etc.)	**City, State**	**Month / Year**

6. Have you had any testing (x-ray, Myelogram, etc.) for your pain? ☐ No ☐ Yes *(Please complete table below.)*

Test (x-ray, MRI, etc,)	**Where was test done?** (Facility name, City, State)	**Month/Year**

7. What assistive devices are utilized due to pain: Wheelchair / Walker / Cane / Brace / Reacher /_____
8. Place a check mark in the box that describes the treatments you have used in the past and the relief it provided:

Treatments	**Significant Relief**	**Moderate Relief**	**Minimal Relief**	**No Relief**
Injections ***Type:***_____				
Chiropractic				
Physical Therapy				
Transcutaneous Electrical Nerve Stimulation (TENS)				
Massage				
Bracing				
Occupational Therapy				
Acupuncture / Pressure				
Other:				

Prior Medications

Instructions: Circle each medication that you have used in the past and identify the relief it provided.

Generic Name *Circle Medication Used*	**Brand Names:** *Circle Medication Used*	**Frequency & Dose**	**Significant Relief**	**Moderate Relief**	**Minor Relief**	**No Relief**
Amitriptyline	Elavil ☐ **Never taken**					
Baclofen	Lioresal					
Carisoprodol	Soma					
Celecoxib	Celebrex					
Clonezapam	Klonopin					
Cyclobenzapine Hydrochloride	Flexeril					
Diazepam	Valium					
Diclofenac Sodium	Voltaren					
Duloxetine Hydrochloride	Cymbalta ☐ **Never taken**					
Escitalopram Oxalate	Lexapro					
Etodolac	Lodine					
Fentanyl Transdermal	Duragesic Patch					
Fluoxetine Hydrochloride	Prozac					
Gabapentin	Neurontin ☐ **Never taken**					
Hydrocodone	Hycodan					
Hydrocodone/Acetaminophen	Lortab / Lorcet / Norco / Vicodin					
Hydrocodone/ASA	Lortab					
Hydrocodone/Ibuprofen	Vicorofen					
Hydromorphone Hydrochloride	Dilaudid					
Ibuprofen	Motrin					
Meloxicam	Mobic					
Metalxalone	Skelaxin					
Methadone Hydrochloride	Dolophine					
Morphine	Roxanol					
Morphine Sulfate	Avinza / Kadin / MS CONTIN / MSIR					
Nabumetone	Relafin					
Naproxen	Naproxyn					
Nortriptyline Hydrochloride	Pamelor					
Oxycodone	Oxycontin/ Oxyfast/ Percolone/Roxicodone					
Oxycodone HCL	OxyIR					
Oxycodone/Actaminophen	Endocet /Percocet/ Roxicet/ Roxilox/Tylox					
Oxycodone/ASA	Endodan / Percodan					
Oxymorphone HCL	Opana					
Paroxetine Hydrochloride	Paxil					
Pregaballin	Lyrica ☐ **Never taken**					
Sertraline Hydrochloride	Zoloft					
Tizanidine Hydrochloride	Zanaflex					
Topiramate	Topamax					
Tramadol Hydrochloride	Ultram					
Tramadol Hydrochloride and Acetaminophen	Ultracet					
Trazodone Hydrochloride	Desyrel					
Venlafaxine Hydrochloride	Effexor					
Zonisamide	Zonegran					
Other Pain Medication:						
Other Pain Medication						

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Current Medication List

Patient Name: _____ Date of Birth: _____

Pharmacy: _____ Allergies: _____

Please fill in the medications you are currently taking and provide the dose. For your safety we would like you to write the medications you are taking and not provide a copy of your list from a previous visit or pharmacy encounter. Please be sure to include any vitamins, herbal medications or alternative medicine.

Medication	Dose	Frequency