

1 Mark T. Malone, M.D.  
 1 Hans E. Bengtson, M.D.  
 1 Omair H. Toor, D.O.  
 1 Matthew G. Thorson, M.D.



Name \_\_\_\_\_ Referring Physician \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Date of Visit \_\_\_\_\_

**A. CHIEF COMPLAINT (Reason for Visit):** \_\_\_\_\_

\_\_\_\_\_

1. What is the exact location of your pain? \_\_\_\_\_  
 \_\_\_\_\_
2. When did you first have this pain? \_\_\_\_\_
3. Please describe your pain. (circle all that apply)
  - Sharp
  - Twisting
  - Dull
  - Burning
  - Aching
  - Pressure
  - Other \_\_\_\_\_
4. How often do you have this pain? \_\_\_\_\_
5. What makes your pain worse? \_\_\_\_\_
6. What makes your pain better? \_\_\_\_\_
7. Previous diagnoses for this pain? \_\_\_\_\_  
 \_\_\_\_\_
8. Previous treatments for this pain? \_\_\_\_\_  
 \_\_\_\_\_
9. Do you have numbness, tingling or weakness in arms or legs? \_\_\_\_\_  
 \_\_\_\_\_
10. Have you had any changes in bowel or bladder function? \_\_\_\_\_
11. On a scale of 1-10 (10 being the worse) how would you rate your pain?  
 1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Circle please

**PAST MEDICAL HISTORY:**

Surgery	Details	Date & Hospital
Back Surgery		
Breast		
Gallbladder		
Hernia Repair		
Hysterectomy/Ovaries		
Tonsillectomy		
Stomach/ Ulcer		
Other		



1 Mark T. Malone, M.D.  
 1 Hans E. Bengtson, M.D.  
 1 Omair H. Toor, D.O.  
 1 Matthew G. Thorson, M.D.



**G. Review of Systems:**

**General**

Y N Decreased Appetite  
 Y N Unexpected Weight Loss  
 Y N Unexpected Weight Gain  
 Y N Fatigue  
 Y N Fever or Chills

**Skin**

Y N Rash  
 Y N Itching  
 Y N Unusual Hair Loss

**Eyes**

Y N Blind Field of Vision  
 Y N Cataracts

**ENT**

Y N Hearing Loss/Ringing  
 Y N Sore Throat/Hoarseness  
 Y N Sinusitis/Sinus Drainage

**Respiratory/Lung**

Y N Sleep Apnea/CPAP Mask  
 Y N Respiratory/Complications w/ Sedation  
 Y N Chronic Bronchitis/Emphysema  
 Y N Difficulty Breathing  
 Y N Persistent Coughing  
 Y N Asthma

**Cardiovascular**

Y N Chest Pain, Pressure, Angina  
 Y N Coronary Artery Disease  
 Y N High Blood Pressure  
 Y N Swelling in Feet or Legs  
 Y N Abnormal Heart Rhythm

**Renal/Urinary/Kidney**

Y N Renal Failure/Insufficiency  
 Y N Electrolyte Disturbances  
 Y N Kidney Stones  
 Y N Difficulty with Urination  
 Y N Urinary Tract Infection  
 Y N Prostate Cancer/Enlarged

**Endocrine**

Y N Diabetes  
 Y N Thyroid Disease

Y N Osteoporosis/Osteopenia

**Gastrointestinal**

Y N Heartburn/Regurgitation  
 Y N Nausea or Vomiting  
 Y N Abdominal Pain  
 Y N Irregular Bowel Habits  
 Y N Loss of Control of Bowels  
 Y N Jaundice  
 Y N Gallstones  
 Y N Hepatitis A, B, C, other  
 Y N Cirrhosis  
 Y N Fluid in Abdomen (ascites)  
 Y N Pancreatitis

**Neurologic**

Y N Headaches  
 Y N Strokes/CVA  
 Y N Seizures

**Musculoskeletal**

Y N Joint Pain/Arthritis  
 Y N Back or Neck Pain  
 Y N Muscle Aching/Weakness

**Blood/Lymph**

Y N Anemia  
 Y N Bruise Easily  
 Y N Past Blood Transfusions  
 Y N Swollen/Tender Lymph Nodes

**Psychiatric**

Y N Drug Abuse/Dependence/Addiction  
 Y N Depression  
 Y N Anxiety  
 Y N Suicide Attempt

**Gynecology**

Y N Pregnant now?  
 Y N Endometriosis  
 Y N Heavy Periods

**Infection**

Y N HIV

**H. Radiology:**

Have you had an X-Ray or MRI? \_\_\_\_\_

When? \_\_\_\_\_ Where? \_\_\_\_\_

**I. Have you been treated for pain management before? Y N**

**J. Work Status: Are you currently working? Y N If not, when did you stop? \_\_\_\_\_**

Who took you off work? \_\_\_\_\_