SOUTHEAST REGIONAL PAIN CENTER
5669 Whitesville Road
Columbus, Georgia 31904

Patient Health Information

Patient Name:_____ Date of Birth:_____Date:_____

Home (Please list names of all living in household)		
House Hold Member Name	Relationship	Age

Personal Safety	
Have you fallen in the last year?	☐Yes ☐No
If yes, how many times? _____ Have you had injuries from falls?	☐Yes ☐No
Do you feel unsteady when walking?	☐Yes ☐No
Do you use any devices to assist with walking? ☐Walker ☐ Cane ☐ Wheelchair ☐ Rollator ☐ Motorized Scooter	
Do you feel unsafe, or have you been harmed in a physical, emotional or sexual manner, in any relationship or recent encounter?	☐Yes ☐No if yes, please describe:
Does a partner, or anyone at home, hurt, hit, or threaten you, or take advantage of you financially?	☐Yes ☐No if yes, please describe:
In the past year, have you had any major life changes or stresses that you feel have impacted your overall health?	☐Yes ☐No if yes, please describe:
Are there any substance abuse issues in your household?	☐Yes ☐No if yes, please describe:
Do you perform daily activities of living (bathing, dressing, cooking, cleaning) for yourself?	☐Yes ☐No if no, please list caregiver:
Are you presently involved in a lawsuit?	☐Yes ☐No if yes, please describe:
In the past year, have you had two weeks or more during which you felt sad, blue or depressed or when you have lost all interest or pleasure in things that you usually care about or enjoyed?	☐Yes ☐No if yes, please describe:
Over the last two weeks, have you experienced little interest or pleasure in doing things?	☐Not at all ☐ Several Days ☐More than half of the days ☐Almost Daily
Over the last two weeks, have you felt down, depressed, or hopeless?	☐Not at all ☐ Several Days ☐More than half of the days ☐Almost Daily

Education History
☐No School ☐1-11th Grades ☐High School Graduate ☐GED ☐Technical School ☐Some College ☐College Graduate

SOUTHEAST REGIONAL PAIN CENTER
5669 Whitesville Road
Columbus, Georgia 31904

Patient Health Information

Employment History		
☐ **No Employment History**		
Occupation	Dates Worked	Reason for leaving position

Allergies	
☐ **I have no medication allergies** ☐ **I have no food/other allergies** ☐ **I have no known intolerances**	
Allergy (please include medication, food and intolerances)	Reaction or Side Effect

Do you currently have, or have ever had, any of the following illnesses or conditions?

- ☐ Abnormal Pap
- ☐ Alcohol/Drug Problem
- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Chronic Lung Disease
- ☐ Colon/Bowel Disease
- ☐ Dementia
- ☐ Diabetes Type I or II
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Gallbladder Disease
- ☐ Glaucoma
- ☐ Gout
- ☐ Hay Fever
- ☐ Head Injury
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart murmur
- ☐ Hepatitis/Liver Disease
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Infection of the uterus
- ☐ Kidney Disease
- ☐ Migraines
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Other Injuries
- ☐ Peripheral Artery Disease
- ☐ Pneumonia
- ☐ Positive TB Test
- ☐ Prostate Problem
- ☐ Psychiatric-Depression
- ☐ Psychiatric-Other
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcer

Include any additional illness/conditions not listed above: _____

_____

SOUTHEAST REGIONAL PAIN CENTER
5669 Whitesville Road
Columbus, Georgia 31904

Patient Health Information

Surgical History		
❑ Appendectomy	❑ C-section	❑ Small intestine surgery
❑ Brain surgery	❑ Eye surgery	❑ Spine surgery
❑ Breast surgery	❑ Fracture surgery	❑ Tubal ligation
❑ CABG	❑ Hernia repair	❑ Valve replacement
❑ Cholecystectomy	❑ Hysterectomy	❑ Vasectomy
❑ Colon surgery	❑ Joint surgery	❑ Vascular surgery
❑ Tonsillectomy	❑ Bunionectomy	❑ Cardiac stent
❑ Appendectomy	❑ Varicose vein surgery	❑ Bladder surgery
❑ Thyroid surgery	❑ Prostate surgery	
❑ Lung surgery	❑ Weight reduction surgery	

Have you ever had a blood transfusion? ❑ No ❑ Yes, approximate dates: _____

Include any additional surgeries not listed above: _____

_____

Hospitalizations		
Date	Location	Reason

Medications (Include contraceptives, vitamins, supplements, etc.)			
Drug Name	Drug Dose	Drug Name	Drug Dose

Please list the names of the physicians and specialists you have seen			
Primary Care		Oncologist	
Gastroenterologist (GI)		Hematologist	
Ear, Nose, Throat (ENT)		Pain Management	
Cardiologist		Orthopedics	
Neurologist		General Surgeon	
OB/GYN		Dermatologist	
Podiatrist		Other	

Patient Health Information

Family History															
Check all boxes that apply			Alcohol Dependance	Cancer Type					Diabetes	Drug Abuse	Heart Disease	Hypertension	Stroke	Mental Illness	Unknown
				Breast	Ovarian	Prostate	Colo-rectal	Other Cancer							
Mother		☐Living ☐Deceased													
Father		☐Living ☐Deceased													
Sibling	☐ Male ☐ Female	☐Living ☐Deceased													
Sibling	☐ Male ☐ Female	☐Living ☐Deceased													
Sibling	☐ Male ☐ Female	☐Living ☐Deceased													
Sibling	☐ Male ☐ Female	☐Living ☐Deceased													
Child	☐ Male ☐ Female	☐Living ☐Deceased													
Child	☐ Male ☐ Female	☐Living ☐Deceased													
Child	☐ Male ☐ Female	☐Living ☐Deceased													
Child	☐ Male ☐ Female	☐Living ☐Deceased													
Grandmother (mothers' side)		☐Living ☐Deceased													
Grandfather (mothers' side)		☐Living ☐Deceased													
Grandmother (Fathers' side)		☐Living ☐Deceased													
Grandfather (Fathers' side)		☐Living ☐Deceased													

Exercise
☐Sedentary (No Exercise) ☐Mild Exercise (Golf, Walking Stairs)
☐Occasional Vigorous Exercise (30-minutes, 1-3 times per week)
☐ Regular Vigorous Exercise (3 times per week or greater or 30-minute exercises)