Phone: (814) 940-2000 *ALLEGHENY PAIN MANAGEMENT* *Michael J. Drass M.D.*
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ALTOONA PA 16602

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY AND RETURN IT TO THE OFFICE AS SOON AS POSSIBLE. IF YOUR APPOINTMENT HAS NOT BEEN SCHEDULED IT WILL BE SCHEDULED AS SOON AS THIS INFORMATION IS RETURNED. PLEASE CONTACT THE OFFICE IF YOU HAVE ANY QUESTIONS (814) 940-2000 THANK YOU.

Name:_____ Date of Birth:_____
Address:_____
Sex: Male_____ Female _____ Height:_____feet _____inches Weight:_____ lbs.
Social Security # _____-_____-_____ Non-Hispanic___ Hispanic___ Race:_____
Religious Creed:_____ Advanced Directives:___Y ___N ___ Interested in information:__Y __N
Home Phone Number: ( )_____-_____ Preferred Language:_____
Cell Phone: (if applicable) ( ) _____-_____ Work Phone Number: ( )_____-_____
Emergency Contact Name:_____ Relationship:_____
Emergency Contact Phone Number:( )_____-_____
Referring Physician's Name:_____
Your Primary Physician:_____ Phone:_____
Your Primary Pharmacy:_____ Phone:_____
INSURANCE:
Name of insurance:_____
ID Number:_____ Group Number:_____
Insurance Carrier's **NAME** if other than yourself:_____
Insurance Carrier's **DATE OF BIRTH** if other than yourself.:_____
Workers Comp: Yes or No If yes Claim #_____ & Date of Injury:_____
Auto Claim: Yes or No If yes Claim #_____ & Insurance Carrier:_____

PAST MEDICAL HISTORY;CHECK ALL THAT APPLY and LIST DATES

HEART /BLOOD VESSELS:
Irregular Heart Beat ___ No ___ Yes Date_____
Congestive Heart Failure ___ No ___ Yes Date_____
Heart Attack ___ No ___ Yes Date_____
High Cholesterol ___ No ___ Yes Date_____
High Blood Pressure ___ No ___ Yes Date_____
Stroke ___ No ___ Yes Date_____

LUNGS/RESPIRATORY:
Asthma ___ No ___ Yes Date_____
Bronchitis (Chronic) ___ No ___ Yes Date_____
COPD ___ No ___ Yes Date_____
Tuberculosis ___ No ___ Yes Date_____

STOMACH/DIGESTIVE:
Diverticulitis ___ No ___ Yes Date_____
Colitis ___ No ___ Yes Date_____
Stomach Ulcer ___ No ___ Yes Date_____
GERD ___ No ___ Yes Date_____
Hepatitis ___ No ___ Yes Date_____ If yes, type: ____ A ____ B ____ C
Irritable Bowel Syndrome ___ No ___ Yes Date_____

MUSCULAR/SKELETAL:
Arthritis ___ No___ Yes
Type: Osteoarthritis or Rheumatoid
Osteoporosis ___ No___ Yes
Osteomyelitis ___ No___ Yes

PAST MEDICAL HISTORY;CHECK ALL THAT APPLY and LIST DATES

KIDNEY:
Renal Failure ___ No ___ Yes Date_____
Dialysis ___ No ___ Yes Date_____
Kidney Stones ___ No ___ Yes Date_____

FEMALE:
Last Menstrual Period ___ No ___ Yes Date_____
Menopausal ___ No ___ Yes Date_____
Pregnant or possibility? ___ No ___ Yes Date_____

MENTAL/EMOTIONAL
Depression ___ No ___ Yes Date_____
Anxiety ___ No ___ Yes Date_____
Schizophrenia ___ No ___ Yes Date_____

GLANDS/HORMONES:
Insulin Dependent Diabetic ___ No ___ Yes Date_____
Non-Insulin Dep. Diabetic ___ No ___ Yes Date_____
Under Active Thyroid ___ No ___ Yes Date_____
Over Active Thyroid ___ No ___ Yes Date_____
Thyroid Surgery ___ No ___ Yes Date_____

BLOOD/ LYMPH NODE PROBLEMS:
Anemia ___ No ___ Yes Date_____
Bleeding Disorder ___ No ___ Yes Date_____
Blood Clots ___ No ___ Yes Date_____
Phlebitis ___ No ___ Yes Date_____

IMMUNE INFECTIOUS PROBLEMS:
HIV ___ No ___ Yes Date_____
Infectious Mononucleosis ___ No ___ Yes Date_____
Shingles ___ No ___ Yes Date_____

CANCER: ___No ___Yes If yes, type:_____ Date_____ Treatment:_____

PAST SURGICAL HISTORY AND HOSPITALIZATIONS

Do you have a cardiac pacemaker? ___ No ___ Yes
Have you ever had NECK or BACK surgery? ___No ___Yes
If yes, list surgery Location:_____ and Date:_____ Surgeon:_____
Do you have any metal implants? ___No ___Yes If yes, are you able to have an MRI if needed?__No __Yes
Do you have cardiac stents in place? ___ No ___ Yes
Have you ever had surgery? ___ No ___ Yes If yes, list surgical procedure, surgical site and date done.

(Side/Site or Location)

Surgery_____ _____Date_____

Surgery_____ _____Date_____

Surgery_____ _____Date_____

Surgery_____ _____Date_____

Surgery_____ _____ Date_____

Surgery_____ _____ Date_____

Do you have problems with Anesthesia (being put to sleep) ___ No ___ Yes If yes, did you have:
___ High Fever ___ Trouble opening mouth ___ Trouble with intubation (breathing tube)
___ Nausea/Vomiting ___ Trouble Awakening Other:_____

___ Family history of anesthesia problems (list)_____

MEDICATIONS

It is **very important** that you list complete and accurate information regarding your medications. Please list the information from your prescription bottles exactly as it is written. Also list all over the counter medicines, vitamins, and/or herb that you take.

Name of Medication	**Reason that you are taking it**	**Dosage/Mg.**	**How often do you take it**

MEDICATION ALLERGIES: If you have medication allergies please list medication and your reaction.

Medication	Type of reaction

OTHER ALLERGIES & REACTIONS

LATEX ALLERGY: ____No ____Yes Reaction:_____
FOOD ALLERGY (Type:) Reaction:_____
DYE ALLERGY (Type:) Reaction:_____
SEASONAL ALLERGIES: Reaction:_____

FAMILY HISTORY:

Heart Disease __Mother __Father __Brother __Sister Other:_____
High Blood Pressure __Mother __Father __Brother __Sister Other:_____
Asthma __Mother __Father __Brother __Sister Other:_____
Arthritis __Mother __Father __Brother __Sister Other:_____
Circle Type: Rheumatoid Arthritis or Osteoarthritis
Diabetes __Mother __Father __Brother __Sister Other:_____
Stroke __Mother __Father __Brother __Sister Other:_____
Bleeding/Clotting Problems __Mother __Father __Brother __Sister Other:_____
Female Health: Breast Cancer __Mother __Sister Other:_____
Male Health: Prostate Cancer __Father __Brother Other:_____
Cancer (Other types; list)_____ __Mother __Father __Brother __Sister Other:_____

SOCIAL HISTORY:

Have you ever use(d) tobacco in any form?___ No ___Yes
If yes please complete the following:
Cigarettes per day:_____ From Year_____ to Year_____
I am interested in smoking cessation information: __Y __N

Do you consume alcohol? ___ No ___Yes
If yes please complete the following:
Type of alcohol:_____
How Much:_____ How Often:_____
I am interested in Alcohol cessation programs:
___ Y___ N

Do you use recreational drugs? ___No ___Yes
If yes, please list:_____
I am interested in information regarding Drug Rehabilitation Programs: ___ Y ___ N

Do you consume caffeine? ___No ___Yes If yes list type:_____ How Often:_____
Marital Status: __Single __Married __Separated __Divorced __Living with partner __Widowed
List individuals living with you and relationship to you:
_____ Relationship:_____
_____ Relationship:_____
_____ Relationship:_____
Functional Status: __Full time employed __Part time employed __Homemaker __Retired __Disabled
Occupation:_____ Children: ___No ___Yes If yes, list number:_____

REVIEW OF SYSTEMS: **(**Please check all that apply **X)**

General Health Problems:
__ Change in appetite __ Unintended weight loss
__ Sleeping problems __ Fever
__ Fatigue __ Weight Gain

Head/Face
__ Headache __ Face Pain

Eye
__ Blurred Vision __ Double Vision
__ Loss of Vision __ Wear glasses or contacts

Ear
__ Hearing Loss __ Ringing in the Ears
__ Dizziness __ Wear hearing aid(s)

Mouth/Throat
__ Change in voice __ Snoring __Sore Throat
__ Mouth Ulcers __ Dentures; If yes circle location ↑ ↓

Neck
__ Neck lumps or masses __ Neck pain
__ Swollen glands

Stomach Problems
__ Stomach Pain __ Constipation
__ Constipation from Pain Medications
__ Diarrhea __ Heartburn
__ Indigestion __ Nausea
__ Vomiting __ Hemorrhoids

Urinary Problems
__ Urinating more than usual __ Kidney Stones
__ Difficulty or painful urinating
__ Kidney Dialysis __ Blood in urine

Bones/Joints/Muscles
__ Back Pain __ Neck Pain
__ Spasms __ Painful joints __ Stiffness
__ Swollen joints __ Muscle cramps
__ Shoulder Pain __ Hip Pain

Brain/Nervous System
__ Change in alertness __ Seizures
__ Loss of consciousness __ Numbness

Heart/Circulation

__ Blacking out or fainting __ Leg Cramps
__ Chest Pain __ Irregular Heartbeat
__ Bluish color to lips or fingernails
__ Swelling of the feet or ankles
__ Heart Murmurs

Lung or Respiratory Problems

__ Shortness of breath
__ Wheezing
__ Productive Cough
__ Non-Productive Cough

Problems with Glands/ Hormones

__ Feel cold all the time __ Feel uncomfortably hot
__ Increased appetite __ Increased thirst
__ Increased fatigue __ Unwanted weight change
__ Neck has enlarged

Problems with Blood/ Lymph Nodes

__ Bruise easily __ Bleed heavily after injury

Problems with Allergies

__ Food intolerances __ Frequent sneezing
__ Hives __ Post nasal drainage
__ Severe reaction to insect bites or bee stings

Skin

__ Rash __ Itching __ Psoriasis
__ Eczema __ Dry flaking skin

Mental/ Psychiatric

__ Anxiety __ Depression
__ Hallucinations __ Suicidal thoughts/tendencies
__ Compulsive behavior(s)

__INFECTIOUS__

Do you currently have or have you had MRSA a (Methicillin Resistant Staphylococcus Aureus) infection or any other MDRO (Multi Drug Resistant Organism) infection? _____No _____Yes (if yes, continue)

Infection site:_____
Treating Doctor and/or hospital:_____
Date infection diagnosed:_____
Was the infectious site cultured _____No _____Yes (If Yes) Location of results:_____

Please list the reason(s) that you have been referred to our practice. Your chief complaint/concern and the location of your pain._____

_____

_____

_____

Thank you for taking the time to complete this initial Patient Health History. The information will remain confidential and enables us to better meet your health care needs. Please call the office if you have any questions regarding completion of these forms. We look forward to participating in your health care.

IMPORTANT: AS A REMINDER WE ASK THAT YOU BRING YOUR FILMS, (MRI) (CT SCAN), WITH YOU TO YOUR APPOINTMENT. YOU WILL NEED TO PICK THEM UP FROM THE AGENCY THAT COMPLETED THE TEST. THANK YOU IN ADVANCE.