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Michael J. Drass, M.D.

ALLEGHENY PAIN MANAGEMENT
1402 NINTH AVENUE
ALTOONA, PA 16602
Patient Referral Packet

FOR OFFICE USE:
Sent:_____ **Yes**_____
Rec:_____ **No**_____
Ent. By:_____ **MD NK AR**

Today's Date:_____

Name:_____ Date of Birth:_____
Address:_____
EMAIL ADDRESS:_____ ***Are you interested in "Patient Portal"*** Y ___ N ___
Sex: Male_____ Female _____ Ht: _____feet _____inches Weight:_____ lbs.
Social Security # _____-_____-_____ Non-Hispanic____ Hispanic____ Race:_____
Religious Creed:_____ Adv. Directives: Y___ N ___ Request info: Y ___ N___
Home Phone Number: ( )_____-_____ Preferred Language:_____
Cell Phone: (if applicable) ( ) _____-_____ Work Phone Number: _____
Emergency Contact Name:_____ Relationship:_____ Date of Birth:_____
Emergency Contact Phone: ( )_____-_____
Physician that referred you to our practice:_____
Your Primary Care (PCP) 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.: _____
SECONDARY INSURANCE: Insurance Carrier Name: _____
ID NUMBER:_____ GROUP NUMBER:_____
WORKER'S COMP INFORMATION:
YES or NO If yes **Claim #**_____ **Date of Injury**:_____
AUTO CLAIM: Yes or No If yes **Claim #**_____ **Insurance Carrier**:_____
Insurance Adjustor's name and contact phone #:_____

PAST MEDICAL HISTORY; PLEASE CHECK IF APPLICABLE and LIST DATES.

HEART /BLOOD VESSELS:
Irregular Heart Beat ___ Date_____
Congestive Heart Failure ___ Date_____
Heart Attack ___ Date_____
High Cholesterol ___ Date_____
High Blood Pressure ___ Date_____
Stroke ____ Date_____

LUNGS/RESPIRATORY:
Asthma ___ Date_____
COPD ___ Date_____
Tuberculosis ___ Date_____

STOMACH/DIGESTIVE:
Diverticulitis ___ Date_____
Colitis ___ Date_____
Stomach Ulcer ___ Date_____
GERD ___ Date_____
Hepatitis ___ Date_____ If yes, type: ____ A ____ B ____ C
Irritable Bowel Syndrome ___ Date_____
Colonoscopy ___ Date_____

MUSCULAR/SKELETAL:
Arthritis: ___ Date___
Type: (**Circle One**) Osteoarthritis or Rheumatoid
Psoratic Arthritis: ___ Date ____
Rheumatologist:_____
Osteomyelitis ___ Date___
Osteoporosis ___ Date___
Dexascan: ___ Date ___

PLEASE COMPLETE ALL SECTIONS OF EACH PAGE

KIDNEY:

Renal Failure ___ Date_____
Dialysis ___ Date_____
Kidney Stones ___ Date_____

FEMALE:

Pregnant or possibility? ___ YES ___ NO Date_____
Mammogram: Date_____

MENTAL/EMOTIONAL

Depression ___ Date_____
Anxiety ___ Date_____
Schizophrenia ___ Date_____
Bipolar Disorder ___ Date_____

GLANDS/HORMONES:

Insulin Dependent Diabetic ___ Date_____
Non-Insulin Dep. Diabetic ___ Date_____
Under Active Thyroid ___ Date_____
Over Active Thyroid ___ Date_____
Thyroid Surgery ___ Date_____

BLOOD/ LYMPH NODE PROBLEMS:

Anemia ___ Date_____
Bleeding Disorder ___ Date_____
Blood Clots ___ Date_____

IMMUNE INFECTIOUS PROBLEMS:

HIV ___ Date_____ Lupus ___ Date_____
Infectious Mononucleosis ___ Date_____ Psoriasis ___ Date_____
Shingles ___ Date_____
CANCER: (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 (If YES; Doctor):_____
Do you take an anticoagulant "blood thinner"? ___No ___Yes (If yes) Name:_____ & Dr:_____

SURGICAL HISTORY	**Body Part Affected:**	**Side: RIGHT or LEFT (if applicable)**	
Surgery_____		R or L	Date_____
Surgery_____		R or L	Date_____
Surgery_____		R or L	Date_____
Surgery_____		R or L	Date_____
Surgery_____		R or L	Date_____
Surgery_____		R or L	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 (describe):_____

PLEASE COMPLETE ALL SECTIONS OF EACH PAGE

MEDICATIONS

Please list medications accurately using the information from your prescription bottles. Additionally, list all over the counter medications and supplements that you take regularly.

Name of Medication	Reason you are taking it	Milligrams/dosage	How often do you take it

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

Medication	Type of reaction

____ **NO ALLERGIES**

OTHER ALLERGIES & REACTIONS

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

OTHER:

COVID-19 Vaccine: ____ No ____ Yes Date: _____ Type: _____
Flu Vaccine: ____ No ____ Yes Date:_____ by whom:_____
Pneumonia Vaccine: ____ No ____ Yes Date _____ by whom:_____

PLEASE COMPLETE ALL SECTIONS OF EACH PAGE

INFECTIOUS

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

Date you had the infection:_____ Location of the Infection:_____

Treating Doctor and/or hospital:_____

Was the infectious site cultured? _____ No _____ Yes (If Yes) Location of lab results:_____

FAMILY HISTORY:

(M) MATERNAL or (P) PATERNAL

Heart Disease	__Mother	__Father	__Brother	__Sister	Other:_____	M or P
High Blood Pressure	__Mother	__Father	__Brother	__Sister	Other:_____	M or P
Asthma	__Mother	__Father	__Brother	__Sister	Other:_____	M or P
Arthritis	__Mother	__Father	__Brother	__Sister	Other:_____	M or P

Circle Type: Rheumatoid Arthritis or Osteoarthritis ***Circle One:***

Diabetes: __Mother __Father __Brother __Sister Other: _____Type: **Insulin Dependent or Non-Insulin**

Stroke __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:

TOBACCO USE: ○ Current User; Packs per day? _____ How many years? _____ Quit date: _____
○ Former User ○ Never Used ○ I am interested in smoking cessation information.

ALCOHOL USE: Do you consume alcohol? ___ No ___Yes; If yes type: _____
○ Social Use ○ Daily Use of Alcohol ○ Current Alcoholism ○ History of Alcoholism

ILLEGAL DRUG USE: ○ Deny use of illegal drugs ○ Currently use illegal drugs ○ Formerly used illegal drugs
Have you ever abused narcotic or prescription medications? Yes_____ No _____
○ I am interested in information regarding Drug Rehabilitation.
Caffeine Use: ○ Occasionally ○ Daily ○ Rarely ○ Never

MARITAL STATUS: ___Single ___Married ___Separated ___Divorced ___Living with partner ___Widowed

Children: ___No ___Yes If yes, list number:_____

List individuals living with you and relationship to you:

_____ Relationship:_____

_____ Relationship:_____

Functional Status: ___Full-time employed___ Part-time employed ___Homemaker ___Retired___ Disabled

Occupation:_____

PHYSICAL THERAPY:

Have you had Physical Therapy?___Yes ___No

Reason for Physical Therapy:_____

Where did you receive Physical Therapy?(Agency)_____

Length of time (in weeks) that you received physical therapy: _____What year? _____

How effective was your Therapy: (Circle One) * **NOT EFFECTIVE * SOMEWHAT EFFECTIVE * EFFECTIVE * MADE PAIN WORSE**

CHIROPRACTIC CARE:

Have you had treatment by a Chiropractor? ___ Yes ___ No

Reason for treatment:_____

Where did you receive treatment? (Agency) _____

Length of time you were treated in weeks: _____ What year? _____

How effective was your treatment: (Circle One) * **NOT EFFECTIVE *SOMEWHAT EFFECTIVE * EFFECTIVE * MADE PAIN WORSE**

PLEASE COMPLETE ALL SECTIONS OF EACH PAGE

HISTORY OF NON-STEROIDAL MEDICATION USE: (Anti-inflammatory medication)
Examples:**Aleve, Advil, Ansaid, Celebrex, Daypro, Diclofenac, Ecotrin, Ibuprofen, Mobic, Naproxen**

CIRCLE ONE:

Name of Medication:_____Length of use:_____ Effectiveness:**25% 50% 75% 100%**
Name of Medication:_____Length of use:_____ Effectiveness: **25% 50% 75% 100%**
Name of Medication:_____Length of use:_____ Effectiveness: **25% 50% 75% 100%**

HISTORY OF PAIN MEDICATION USE:
Examples**: Actiq, Avinza, Butrans, Codeine, Demerol, Dilaudid, Duragesic, Endocet, Fentanyl, Hydrocodone, Lortab, Morphine, MS Contin, Nucynta, Oxycontin, Percocet, Ultram**

CIRCLE ONE:

Name of Medication:_____Length of use:_____ Effectiveness: **25% 50% 75% 100%**
Name of Medication:_____Length of use:_____ Effectiveness: **25% 50% 75% 100%**
Name of Medication:_____Length of use:_____ Effectiveness: **25% 50% 75% 100%**
Name of Medication:_____Length of use:_____ Effectiveness: **25% 50% 75% 100%**

HISTORY OF MUSCLE RELAXOR USE:
Examples: **Flexeril (Cyclobenzaprine), Amrix, Skelaxin (Metaxalone), Soma (Carisoprodol), Lioresal (Baclofen), Norflex (Orphenadrine), Zanaflex (Tizanidine).**

CIRCLE ONE:

Name of Medication:_____Length of use:_____ Effectiveness: **25% 50% 75% 100%**
Name of Medication:_____Length of use:_____ Effectiveness: **25% 50% 75% 100%**
Name of Medication:_____Length of use:_____ Effectiveness: **25% 50% 75% 100%**
Name of Medication:_____Length of use:_____ Effectiveness: **25% 50% 75% 100%**

HISTORY OF ANTI-DEPRESSASNT & ANTICONVULSANT USE: (May be used in pain regimen)
Examples: Buspar, Celexa, Cymbalta, Effexor, Lexapro, Paxil, Prozac, Welbutrin, Zoloft, Gabapentin, Lyrica. (Please list medications that may not be listed.)

CIRCLE ONE:

Name of Medication:_____Length of use:_____ Effectiveness: **25% 50% 75% 100%**
Name of Medication:_____Length of use:_____ Effectiveness: **25% 50% 75% 100%**
Name of Medication:_____Length of use:_____ Effectiveness: **25% 50% 75% 100%**
Name of Medication:_____Length of use:_____ Effectiveness: **25% 50% 75% 100%**

MRI SCAN: NOTE: PLEASE BRING CD (s) WITH YOU TO THE VISIT

Body part scanned:_____Date completed:_____Where completed:_____

CT SCAN:
Body part scanned:_____Date completed:_____Where completed:_____

X-RAYS:
Body part x-rayed:_____Date completed:_____Where completed:_____

PLEASE COMPLETE ALL SECTIONS OF EACH PAGE

PLEASE COMPLETE ALL SECTIONS OF THIS LAST PAGE

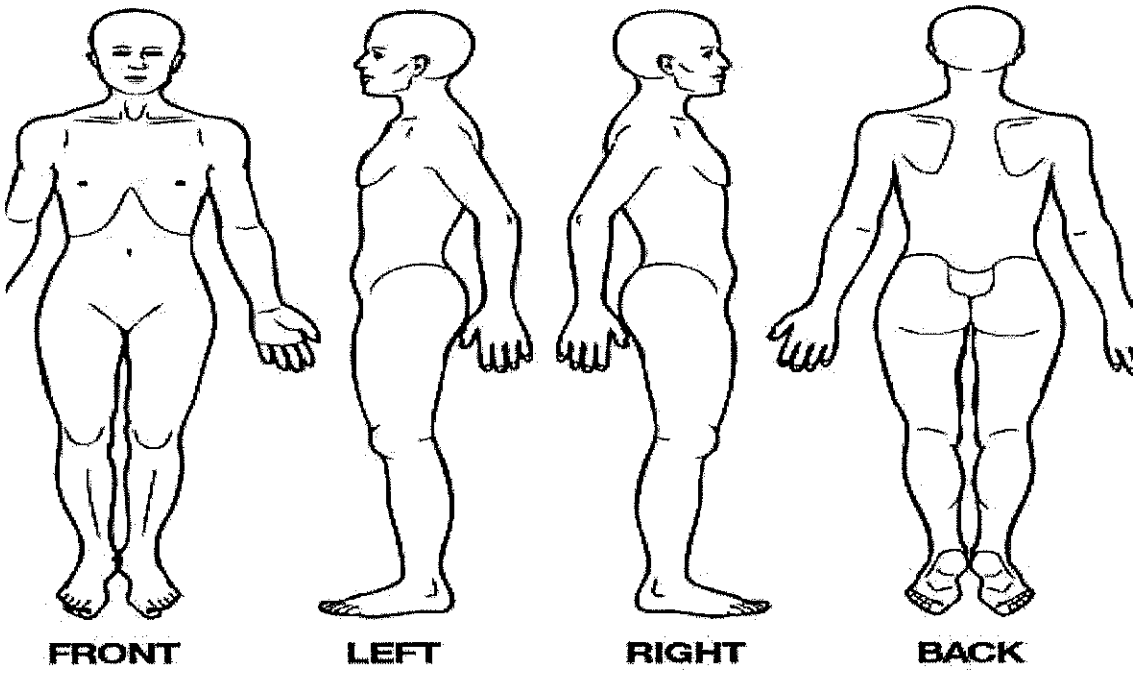
PAIN HISTORY:

Chief complaint (reason for your visit today) _____

Does this pain radiate? If so, to where? _____

Please list any additional areas of pain: _____

Use the diagram below to indicate your areas of pain. Mark an **"X"** on the area that you have pain.



ONSET OF PAIN SYMPTOMS:

Approximately when did the pain begin:_____

What caused the current pain episode? _____

Did the current pain episode begin ○ Gradually ○ Suddenly

Since your pain began, how has it changed? ○ Improved ○ Worsened ○ Stayed the same

INTERVENTIONAL PAIN TREATMENT HISTORY: Check all that apply include date of treatments.

○ Epidural Steroid Injection (Circle all that apply) Cervical/Thoracic/Lumbar_____

○ Joint Injection – Joint(s):_____

○ Medial Branch Blocks/Facet Injections (circle levels) Cervical/Thoracic/Lumbar_____

○ MILD (Minimally Invasive Lumbar Decompression)_____

○ Nerve Blocks Area/Nerves_____

○ Radiofrequency Nerve Ablation (Circle levels) Cervical/Thoracic/Lumbar_____

○ Spinal Cord Stimulator; Trial Only/Permanent Implant_____

○ Trigger Point Injections Where? _____

○ Vertebroplasty/Kyphoplasty Level(s)_____

○ Implanted Pain Pump_____

○ Other:_____

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.