PAIN CONSULTANTS & INTERVENTION- EDWARD POON, MD

3860 Masthead Street N.E., Albuquerque, NM 87109

TODAY'S DATE_____

Patient Information

Last Name | First Name | MI | DOB | Age

Home Address | City | State | Zip | Social Security No.

( ) Day Phone | ( ) Evening Phone | In case of emergency please call | ( ) Phone 1 | ( ) Phone 2

Primary Medical Insurance Carrier | Secondary Medical Insurance Carrier

Name of Employer If This Is A Work Injury | Employer's Phone Number If This Is A Work Injury

Primary Physician's Name | ( ) Phone Number | Referring Physician's Name | ( ) Phone Number

I learn best by: ☐ Verbal Instruction ☐ Visual Demonstration ☐ Written Instruction ☐ Hands On ☐ Any Of These

Chief Complaint

Please describe your **primary pain problem** today: _____

Does your **pain radiate**? ☐ Yes ☐ No If so, please describe: _____

When did your **pain first begin**? _____ What **caused the pain**? (e.g. accident, injury, etc.)_____

On the diagram below please circle the number that best indicates the **severity of your pain.**

NO PAIN — DISTRESSING PAIN — UNBEARABLE PAIN

0 1 2 3 4 5 6 7 8 9 10

Please **describe your pain**, check all that apply:

☐ Aching ☐ Burning ☐ Dull ☐ Numbness ☐ Pulling ☐ Sharp ☐ Shooting ☐ Stabbing
☐ Throbbing ☐ Tingling ☐ Other *describe*: _____

How **often** do you have your pain?

☐ Constantly: 80-100% of the time ☐ Nearly constantly 50-80% of the time ☐ Intermittently 25-50% of the time
☐ Occasionally 25% of the time or less

In general, when is **your pain the worst**? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ No typical pattern

Please check what makes your **pain feel worse**:

☐ Walking ☐ Lifting ☐ Bending ☐ Lying ☐ Standing ☐ Sitting ☐ Rest ☐ Exercise
☐ Touch ☐ Heat ☐ Cold ☐ Weather changes ☐ Temperature Changes
☐ Other *describe:* _____

Please check what makes your **pain feel better**:

☐ Walking ☐ Lifting ☐ Bending ☐ Lying ☐ Standing ☐ Sitting ☐ Rest ☐ Exercise
☐ Touch ☐ Heat ☐ Cold ☐ Weather changes ☐ Temperature Changes
☐ Other *describe:* _____

Please See Next Page

PAIN CONSULTANTS & INTERVENTION- EDWARD POON, MD

3860 Masthead Street N.E., Albuquerque, NM 87109

TODAY'S DATE_____

Chief Complaint

Have you had **involuntary loss of bowel or bladder control**? ☐ Yes ☐ No

Do you experience any **weakness with your pain**? ☐ Yes ☐ No

Please describe any **significant interference** that your pain causes in your **daily activities** (e.g. walking, sleeping, appetite, chores, etc.):

_____

Studies

Have you had any of the following **tests for this pain problem**?

	Ordering Doctor	Date	Facility
☐ MRI			
☐ CAT Scan			
☐ X-Ray			
☐ EMG			

Treatments

Please list any **injections that you've had for this pain problem**:

Injection	Doctor	Date

Please list any **surgeries that you've had**:

Surgery	Surgeon	Date

Other *describe:* _____

Past Medical History

Please check any of the following that you have and put the date diagnosed:

☐ Heart Problems	Date:_____	☐ Hypertension	Date:_____	☐ Circulation Problems	Date:_____
☐ Diabetes	Date:_____	☐ Liver Problems	Date:_____	☐ Cancer	Date:_____
☐ Blood Disorders	Date:_____	☐ Lung Problems	Date:_____	☐ Asthma	Date:_____
☐ Blackouts	Date:_____	☐ Falls	Date:_____	☐ Other *List*:	_____

Please check any of the following:

☐ Tobacco Use	☐ Type: _____	☐ Amount Per Day: _____	☐ Number of Years: _____
☐ Alcohol Use	☐ Type: _____	☐ Amount Per Day: _____	☐ Number of Years: _____
☐ Recreational Drug Use	☐ Type: _____	☐ Amount Per Day: _____	☐ Number of Years: _____

Medications

Please list your **current medications**. Include over the counter medications.

Name of Medication	Prescribing Doctor	Dose	Frequency	Date Started

Other

ALLERGIES

☐ No Allergies ☐ Contrast Dye
☐ Iodine ☐ Shellfish
☐ Betadine ☐ Alcohol
☐ Medications *List*: _____

BLOOD THINNERS

☐ Heparin ☐ Coumadin
☐ Lovenox ☐ Ticlid
☐ Plavix
☐ Other *List*: _____

IMPLANTS

☐ Pacemaker ☐ Portacath
☐ Pump ☐ Rods
☐ Prosthesis
☐ Other *List*: _____

Notes

_____
_____
_____
_____
_____
_____