WOOSTER PAIN AND ANESTHESIA CENTER, LLC

Maher Jeffrey Zackary, MD, MB, BCh
and
Lisa Prebish, NP
WE TREAT YOU LIKE FAMILY
3373 Commerce Parkway
Suite 3
Wooster, Ohio 44691

Phone: (330) 439-4656 Fax: (888) 833-4132, (330) 601-0081
Email: wpac@woosterpaincenter.com Website: woosterpaincenter.com

HEALTH QUESTIONNAIRE

PERSONAL DATA Date: ___-___-___

Name: (first, middle, last) _____ DOB: ___-___-___ Age: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Orthopedic Surgeon: _____ Phone: _____

Spine/ Neurosurgeon: _____ Phone: _____

Pharmacy: _____ Phone: _____

Primary Insurance: _____ Policy Number: _____

Policy Holder: _____ Group Number: _____

For Worker's Compensation
If you are seeing us due to a work related accident, please answer the following questions:

Date of Injury: _____ Case Number: _____
Assigned Caseworker: _____ Phone: _____

For Auto Accident
If you are seeing us due to an auto accident, please answer the following questions:

Date of accident: _____
Auto Insurance: _____ Policy Number: _____ Phone Number: _____
Name of your Attorney: _____ Phone: _____

How did you here of this practice: ❑ Your doctor ❑ other patients ❑ Yellow Pages ❑ Internet ❑ Other: _____

Email Address: _____
or Family Email Address: _____

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CHIEF COMPLAINT

What is the reason for your office visit today? ❑ Neck pain ❑ Arm pain ❑ Back pain ❑ Leg pain ❑ Shoulder pain ❑ Hip pain ❑ Knee pain ❑ Ankle pain ❑ Headaches other reason(s): _____

HISTORY OF PRESENT INJURY

When did this problem start? (Estimate if no specific date) _____
Was there an inciting event to your symptoms? ❑ Work injury ❑ Auto accident other: _____
Did you have these symptoms in the past? ❑ Yes ❑ No If yes, when? _____
Are you seeing other doctor(s) for this problem? ❑ Yes ❑ No Diagnosis? _____
Are you in any legal actions regarding this injury? ❑ Yes ❑ No

What testing have you had for this problem? (Please give date and results if available)
❑ X-rays: _____ ❑ MRI: _____ ❑ Bone scan: _____
❑ CAT scan: _____ ❑ EMG: _____ ❑ Other: _____

What treatment have you had? ❑ Physical Therapy ❑ Chiropractic care ❑ Injections: _____
❑ Surgeries: _____ Other: _____

List the **pain** medications that you have taken, including over-the-counter medications: _____

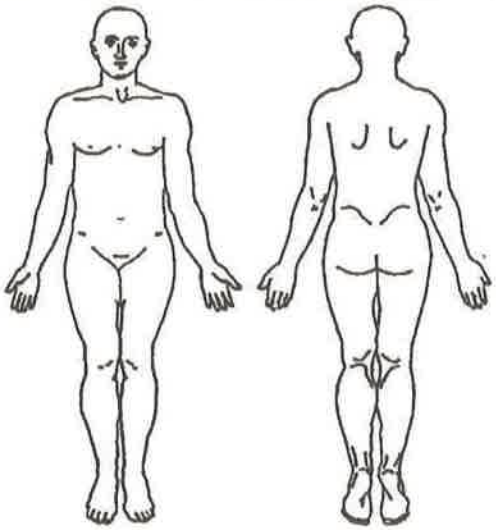
_____

Did you take time off work because of this problem? ❑ Yes ❑ No

If yes, dates off work: _____

Mark on the picture diagram where the pain is using the following:

/ – sharp/stabbing x – burning o – numbness
= – dull s – cramping • – pins & needles



The pain is: ❑ Constant or ❑ Comes and goes
Worse during: ❑ Morning ❑ Noon ❑ Evening ❑ Bedtime
What activities make it worse: _____
What activities make it better: _____

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Circle the level of your pain? 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

REVIEW OF SYSTEM

- Gen ☐ Weight loss ☐ Weight gain ☐ Fever ☐ Fatigue ☐ Loss of appetite ☐ Nausea ☐ Vomiting
- Skin ☐ Skin problem ☐ Rash ☐ Psoriasis ☐ Slow healing ☐ Easy bruising ☐ Itching
- Neuro ☐ Light headed/dizziness ☐ Fainting ☐ Weakness ☐ Stroke ☐ Tremor ☐ Seizure ☐ Memory loss
- Eyes ☐ Vision problem ☐ Glaucoma ☐ Blurred vision ☐ Double vision
- ENT ☐ Ear pain ☐ Hearing loss ☐ Ear noises ☐ Nose bleed ☐ Sore throat ☐ Hoarseness ☐ Dental problems
- Cardiovascular ☐ Chest pain ☐ Chest pressure ☐ Shortness of breath ☐ Irregular heart beat ☐ Murmurs
- Respiratory ☐ Coughing ☐ Difficulty breathing ☐ Asthma/Wheezing ☐ Coughing up blood
- Gastrointestinal ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Bloody stool ☐ Pain in stomach ☐ Ulcers ☐ Hepatitis
- Genitourinary ☐ Painful urination ☐ Frequent urination ☐ Bloody urine ☐ Kidney stone ☐ Incontinence ☐ Loss of libido ☐ Sexual difficulty ☐ Infection
- Endocrine ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Diabetes ☐ Parathyroid problems
- Hematology ☐ Anemia ☐ Bleeding disorder ☐ Easy bleeding ☐ Lymphoma/Leukemia ☐ Sickle cell disease
- Immunologic ☐ Catch cold easily ☐ HIV/AIDS ☐ Fever ☐ Hay fever ☐ Frequent sinus problems ☐ Allergies
- Musculoskeletal ☐ Arthritis ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Compression fracture ☐ Head injury ☐ Neck injury ☐ Lower back injury ☐ Spinal trauma ☐ Birth trauma ☐ Birth defect ☐ Lupus ☐ Spina bifida ☐ Gout ☐ Osteoporosis ☐ Muscular dystrophy ☐ Muscle pain ☐ Scoliosis
- Women only ☐ Irregular periods ☐ Premenstrual depression ☐ Hot flashes ☐ Menstrual cramps ☐ Vaginal discharge ☐ Hysterectomy ☐ Breast surgery ☐ Nipple discharge ☐ Breast lumps ☐ Last mammogram _____
- Men only ☐ Burning on urination ☐ Dripping after urination ☐ Prostate problems ☐ Difficulty starting urination
- Psychiatric ☐ Depression ☐ Anxiety ☐ Panic attacks ☐ OCD ☐ Manic ☐ Bipolar ☐ Suicidal attempts ☐ Suicidal ideation ☐ Homicidal ☐ Hallucination ☐ Psychosis ☐ Other _____

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PAST MEDICAL HISTORY

Do you have any of the following conditions? (Check all that apply)

❑ Coronary artery disease	❑ Heart attacks	❑ High blood pressure	❑ Diabetes
❑ Seizures	❑ Stroke(s)	❑ Anemia (low blood count)	❑ Asthma
❑ Thyroid disease	❑ TB	❑ Hepatitis	❑ Kidney disease
❑ Peripheral vascular disease	❑ Ulcers	❑ HIV	❑ Emphysema

❑ Cancer: _____

PAST SURGICAL HISTORY

❑ Spine (Cervical, Thoracic, Lumbar)_____

❑ Joint replacement:_____

❑ List other surgeries and dates: _____

❑ List any prior accidents or work injuries: _____

MEDICATION HISTORY. (Please list all current medications)

Medication:	Dosage:	Frequency: (how often)	Prescribing Physician:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

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Do you have any **Allergies**? ❑ Yes ❑ No If yes, list them?

_____

_____

FAMILY HISTORY

Are there any medical conditions that are common in your family? ❑ Yes ❑ No

If yes, list: _____

SOCIAL HISTORY

Tobacco use: ❑ Cigarettes ❑ Cigars ❑ others: _____How much per day? _____For how long? _____

Alcohol use: ❑ Beer ❑ other: _____How often? _____For how long? _____

Illicit drug use: ❑ Yes ❑ no If yes, what type(s): _____How often? _____For how long? _____

Do you have a drug or alcohol dependency? ❑ Yes ❑ No If yes, did you have drug rehabilitation? ❑ Yes ❑ No

Occupation: _____❑ Full-time ❑ Part-time Marital Status: ❑ S ❑ M ❑ W ❑ D

Family Status: Living with_____Disability: ❑ No ❑ Yes (Type)_____

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Name: _____ Date: _____

The following are some questions given to all patients at the Wooster Pain and Anesthesia Center, who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?.....**0 1 2 3 4**

2. How often do you smoke a cigarette within an hour after you wake up?.....**0 1 2 3 4**

3. How often have any of your family members, including parents and grandparents, had a problem with Alcohol or Drugs?.....**0 1 2 3 4**

4. How often have any of your close friends had a problem with alcohol or drugs?.....**0 1 2 3 4**

5. How often have others suggested that you have a drug or alcohol problem?.....**0 1 2 3 4**

6. How often have you attended an AA or NA meeting?.....**0 1 2 3 4**

7. How often have you taken medication other than the way that it was prescribed?.....**0 1 2 3 4**

8. How often have you been treated for an alcohol or drug problem?.....**0 1 2 3 4**

9. How often have your medications been lost or stolen?.....**0 1 2 3 4**

10. How often have others expressed concern over your use of medication?.....**0 1 2 3 4**

11. How often have you felt a craving for medication?.....**0 1 2 3 4**

12. How often have you been asked to give a urine screen for substance abuse?.....**0 1 2 3 4**

13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?.....**0 1 2 3 4**

14. How often, in your lifetime, have you had legal problems or been arrested?.....**0 1 2 3 4**

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Please include any additional information you wish, about the above answers. Thank you.

_____

_____

_____

The above information is complete and accurate to the best of my knowledge.

This form is completed by:

❑ Patient Signature: _____ Date: _____

❑ Parent/Guardian Signature: _____ Name/Relation: _____