WOOSTER PAIN AND ANESTHESIA CENTER, LLC

Maher Jeffrey Zackary , MD, MB, BCh

WE TREAT YOU LIKE A FAMILY

3373 Commerce Parkway, Suite 3

Wooster, Ohio, 44691

Phone: (330) 439-4656 or (330) 284-9119 Fax: (888) 833-4132

WPAC2013@gmail.com Woosterpaincenter.com

HEALTH QUESTIONAIRE

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: _____

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): _____

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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? _____ 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

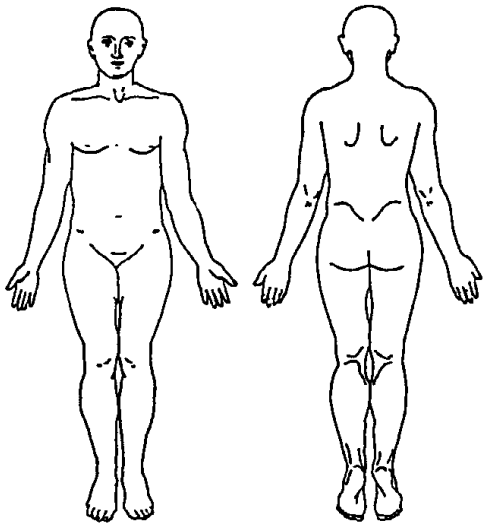
The pain is: _ constant or _ comes and goes

Worse during: _ morning _ noon _ evening _ bedtime

What activities make it worse: _____

What activities make it better: _____

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



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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 _____

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

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_ 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-_____	_____	_____	_____

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

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Family Status: Living with_____

Disability: _ No _ Yes (Type)_____

SOAPP[SM] Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at Wooster Pain and Anesthesia Center, LLC 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	

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

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

This form is completed by

_ Patient X _____ Date _____

_ Other X _____ Name / Relation _____