

## PITTSBURGH PAIN PHYSICIANS New Patient Intake Form



Your completed intake paperwork helps our physicians get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call (412)533-2202 if you have any questions or are unsure how to complete any section of this form.

Today's Date **Patient** Your Name: Social Security Number: Street Address: Date of Birth:\_\_\_\_\_Age: \_\_\_\_\_ Height: Weight: lbs City/State/Zip:\_\_\_\_\_ Email: Gender: Male Female Preferred Phone: Driver's License #/State: \_\_\_\_\_ Secondary Phone: PCP Phone #: Primary Care Doctor:\_\_\_\_\_ Emergency Contact Name: Phone: Relationship: Marital Status: Married Single Divorced Widowed Other Race: American Indian or Alaskan Native Asian or Pacific Islander Black White Refuse to Report Ethnicity: Hispanic Non---Hispanic Refuse to Report Primary Language: English Spanish Other Referral Were you referred to our clinic by another physician? If so, whom? If not, how did you hear about us? Preferred Pharmacy Pharmacy Name:\_\_\_\_\_\_Phone Number:\_\_\_\_\_ Street Address: City/State/Zip: Primary Insurance Plan Payer (e.g. BC/BS):\_\_\_\_\_ Plan: Policy/I.D. Number: Group Number: Complete this box if you are *not* the policy holder for your primary insurance Child Other: Insurance policy holder: Self Spouse Policy Holder Name: Policy Holder Gender: Female Male Date of Birth: Social Security Number:

Secondary Insurance Plan (if any)	
Payer (e.g. BC/BS):	Plan:
Policy/I.D. Number:	_Group Number:
Complete this box if you are <i>not</i> the policy holder for your	secondary insurance
Insurance policy holder: Self Spouse Child Ot	
Policy Holder Name:	
Date of Birth:	Social Security Number:
Information	
Complete this section only if your visit today	s related to a Workers
Compensation claim	
Workers Comp Company:	Agent Name:
Phone number:	Fax Number:
Claim Number:	Date of initial injury:
Dain Description	
Pain Description	
Use the pain scale described below to rate your pain	for the questions below:
0 - Painfree 1 - Very minor annoyance, occasional minor twinges	
2 – Minor annovance, occasional strong twinges	1 2 3 4 5 6 7 8 9
<ul><li>3 – Annoying enough to be distracting</li><li>4 – Can be ignored if you are really involved in your</li></ul>	1 2 3 4 5 6 7 8 9 <b>1 1 1 1 1 1 1 → 10</b>
work/task, but still distracting	
<ul><li>5 – Cannot be ignored for more than 30 minutes</li><li>6 – Cannot be ignored for any length of time, but you car</li></ul>	n still go to work and participate in social activities
<ul> <li>7 - Makes it difficult to concentrate, interferes with sleep,</li> <li>8 - Physical activity is severely limited. You can read and to</li> </ul>	
9 – Unable to speak, crying out or moaning uncontrollably,	
10 – Unconscious, pain makes you pass out	
What number on the pain scale (010) best de	escribes your pain <b>right now</b> ?
What number on the pain scale (010) best de	
What number on the pain scale (010) best de	•
	escribes your average pain over the last month?
	. ,

Use this diagram to indicate the location letters that best describe your symptoms:		Mark the drawing with the following
"N" numbness "S" stabbing "B" burning "P" pins and needles "A" aching	Right	Left Right
Where is your worst area of pain located? Does this pain radiate?		
If so, where? Please list any additional areas of pain:		
Onset of Symptoms		
Approximately when did this pain begin? What caused your current pain episode?		
Is your pain the result of a Motor Vehicle sustained to your person by negligence of another		Jury (legal term describing injury
How did your current pain episode begin		
Since your pain began, how has it change	ed?  Decreased  Increase	ed Stayed the same
Pain Description		
Check all of the following that describe of	f your pain:	
□ Aching □ Hot/Burning □ Cramping □ Numbness □ Dull □ "Shock"like □ Tingling/Pins and Needles	<ul><li>Shooting</li><li>Spasming</li><li>Squeezing</li></ul>	<ul><li>Stabbing/Sharp</li><li>Throbbing</li><li>Tiring/Exhausting</li></ul>
What word best describes the frequency of y	our pain? Constant	Intermittent (Comes and goes)
When is your pain at its worst?	•	nings IMiddle of the night RS With Activity

In the past three mo	onths have you develop	bed any new:	
	☐ Bladder incontinence		
☐ Difficulty Walking			_
□ Numbness/Tingling — \	Where?	U weakness – Wher	e:
I HAVE NOT RECENTLY	DEVELOPED ANY OF THE ABO	OVE CONDITIONS.	
Diagnostic Testing a	nd Imaging		
Mark all of the follow complaints:	ving tests you have had	that are related to you	r current pain
MRI of the		Date:	Facility:
Xray of the		Date:	Facility:
CT scan of the		Date:	Facility:
☐EMG/NCV study of th	e	Date:	Facility:
Other diagnostic testing	g:		
	DIAGNOSTIC TESTS PERFORI	NED FOR INT COMMENT TO	in com Dants.
Pain Treatment Hist  Mark all of the following	<b>ory</b> g pain treatments you have <sub>l</sub>	previous had & percent of	pain relief obtained w
Pain Treatment Hist  Mark all of the following  Prior Pain Clinics or Pa	ory g pain treatments you have pain Physicians: Where/Who?	previous had & percent of	pain relief obtained w
Pain Treatment Hist  Mark all of the following	ory g pain treatments you have pain Physicians: Where/Who?	previous had & percent of	pain relief obtained wi
Pain Treatment Hist  Mark all of the following  Prior Pain Clinics or Pa	ory g pain treatments you have pain Physicians: Where/Who?%	previous had & percent of	pain relief obtained wi
Pain Treatment Hist Mark all of the following Prior Pain Clinics or Pa Physical Therapy	ory g pain treatments you have pain Physicians: Where/Who?%%	previous had & percent of	pain relief obtained wi
Pain Treatment Hist Mark all of the following Prior Pain Clinics or Pa Physical Therapy Spine Surgery Chiropractic	ory g pain treatments you have pain Physicians: Where/Who?%%	previous had & percent of	pain relief obtained wi
Pain Treatment Hist Mark all of the following Prior Pain Clinics or Pa Physical Therapy Spine Surgery Chiropractic Discogram – (Circle ty	ory g pain treatments you have pain Physicians: Where/Who?%%	previous had & percent of	pain relief obtained wi
Pain Treatment Hist Mark all of the following Prior Pain Clinics or Pa Physical Therapy Spine Surgery Chiropractic Discogram – (Circle ty Epidural Steroid Inject	ory g pain treatments you have pain Physicians: Where/Who?%% pe: Cervical / Thoracic / Lun	previous had & percent of  hbar) %  Il / Thoracic / Lumbar)	pain relief obtained wi
Pain Treatment Hist Mark all of the following Prior Pain Clinics or Pa Physical Therapy Spine Surgery Chiropractic Discogram – (Circle ty Epidural Steroid Inject	ory g pain treatments you have pain Physicians: Where/Who?%% pe: Cervical / Thoracic / Lunction — (Circle type: Cervica	previous had & percent of  hbar) %  I / Thoracic / Lumbar)	pain relief obtained wi
Pain Treatment Hist Mark all of the following Prior Pain Clinics or Pa Physical Therapy Spine Surgery Chiropractic Discogram — (Circle ty Epidural Steroid Inject Nerve Blocks — (Area/ Medial Branch Blocks	ory g pain treatments you have pain Physicians: Where/Who?%% % pe: Cervical / Thoracic / Lunction — (Circle type: Cervica	previous had & percent of  hbar) %  I / Thoracic / Lumbar) %  type: Cervical / Thoracic /	pain relief obtained wi
Pain Treatment Hist Mark all of the following Prior Pain Clinics or Pa Physical Therapy Spine Surgery Chiropractic Discogram — (Circle ty Epidural Steroid Inject Nerve Blocks — (Area/ Medial Branch Blocks Radiofrequency Ablati	ory g pain treatments you have pain Physicians: Where/Who?%% pe: Cervical / Thoracic / Lunction — (Circle type: Cervical Nerves:)or Facet Injections — (Circle	previous had & percent of  hbar) %  I / Thoracic / Lumbar)  type: Cervical / Thoracic / Thoracic / Lumbar)	pain relief obtained wi
Pain Treatment Hist Mark all of the following Prior Pain Clinics or Pa Physical Therapy Spine Surgery Chiropractic Discogram — (Circle ty Epidural Steroid Inject Nerve Blocks — (Area/ Medial Branch Blocks Radiofrequency Ablati Spinal Column Stimula	g pain treatments you have pain Physicians: Where/Who?  —— %  — %  pe: Cervical / Thoracic / Lunction — (Circle type: Cervical Nerves:)  or Facet Injections — (Circle type: Cervical /	previous had & percent of  hbar) %  If / Thoracic / Lumbar)  type: Cervical / Thoracic / Thoracic / Lumbar)  / / Permanent Implant)	pain relief obtained wi
Pain Treatment Hist Mark all of the following Prior Pain Clinics or Pa Physical Therapy Spine Surgery Chiropractic Discogram – (Circle ty Epidural Steroid Inject Nerve Blocks – (Area/ Medial Branch Blocks Radiofrequency Ablati Spinal Column Stimula Joint Injections – (Reg	g pain treatments you have pain Physicians: Where/Who?  — %  — %  pe: Cervical / Thoracic / Lunction — (Circle type: Cervical Nerves:)  or Facet Injections — (Circle type: Cervical / ator — (Circle type: Trial Only	previous had & percent of P	pain relief obtained wi
Pain Treatment Hist Mark all of the following Prior Pain Clinics or Pa Physical Therapy Spine Surgery Chiropractic Discogram — (Circle ty Epidural Steroid Injection Nerve Blocks — (Area/ Medial Branch Blocks Radiofrequency Ablati Spinal Column Stimula Joint Injections — (Reg	g pain treatments you have pain Physicians: Where/Who?  """""""""""""""""""""""""""""""""""	previous had & percent of polynomials of the polyno	pain relief obtained wi

History	
Have you ever had anesthesia (sedation for a su	irgical procedure)?   Yes  No
If so, have you ever had any adverse reaction to Which type of anesthesia did you react adversel Local anesthesia Epidural General anest	y to? Please check all that apply.
Do you have a family history of adverse reaction Local anesthesia Epidural General anest	· · · · · · · · · · · · · · · · · · ·
Past Surgical History	
	had done in the past including the date tune and
any pertinent details.	had done in the past, including the date, type, and
any pertinent details.	
Abdominal Surgery	Joint Surgery
Gallbladder removal	Shoulder
Appendectomy	□Hip
Other	☐ Knee
Female Surgeries	<u>Spine / Back Surgery</u>
Caesarean section	Discectomy (levels)
Hysterectomy	Laminectomy (levels)
Laparoscopy	Spinal fusion (levels)
Ovarian	
Other	Other Common Surgeries
Heart Company	Hemorrhoid surgery
Heart Surgery	Hernia repair
□ Valve replacement	Thyroidectomy
□ Aneurysm repair  □ Stent placement	<ul><li>Tonsillectomy</li><li>Vascular surgery</li></ul>
Other	Vasculai suigeiy
Please list any other surgeries and dates (attach	an additional sheet if necessary)
	<del></del>
□ I HAVE NEVER HAD ANY SURGICAL PROCEDURE	S DONE
BLOOD THINNING MEDICATIONS	S DONE.
	lood thingage you are taling.
Please indicate which (if any) of the following bl	
□ Aspirin/Ecotrin(dose) □ Aggrenox □ Cou	umadin/Warfarin
□ Brilinta □ Effient □ Prasugrel □ Ticlid □ Indome	ethacin/Indocin <a>Diclofenac</a> /Arthrotec
□ Ibuprofen/Advil/Motrin □ Naproxen/Aleve □ Ce	elebrex/Celcoxib
□Xarelto □Other	_ ,

## **CURRENT MEDICATIONS**

Medication Name	Dose	Frequency	Medication	Name	Dose	Frequency
	C THAT DID N	OT LIFLE DAIN OR	CALISED SIDE FE	EECTS (IN	CLUDE DOS	FC)
OR PAIN MEDICATIONS Medication Name	Dose	Frequency	Medication Na		Dose	Frequency
		_				

Allergies
Do you have any known drug allergies?   Yes  No
If so, please list all medications you are allergic to.
Medication Name Allergic Reaction Type
Topical Allergies: Iodine/Contrast Latex Tape Betadine
Are you allergic to shellfish?   Yes  No
Family History
Mark all appropriate diagnoses as they pertain to your biological MOTHER AND FATHER only.
Arthitis Cancer Diabetes Headaches Heat Disease Hood Pressure Richney Problems Osteopologis Rheimatoid Arthitis
Arthitis Carcer Diabetes Healt Disease Hold Disease Right Cholesterd Liver Problems Osteoporosis Rheimatoid Arthitis
Arthitis Carcer Diabetes Healtaches High High Linde Kidney Proble Osteopords Rheimatolic Stroke
Mother
Father
Other medical problems:
□I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY. □ I AM ADOPTED (No Medical History Available).
Social History
Are you capable of becoming pregnant?   Yes   No  /f so, are you currently pregnant?   Yes   No
Highest level of education obtained: Grammar school High School College Postgraduate
Alcohol Use: Daily Limited Use History of Alcoholism Current Alcoholism
□ Never Drinks Alcohol □ Drinks Alcohol Socially
Tobacco Use: Current Tobacco User Packs Per Day How many years smoker
□Former Tobacco User □Has Never Used Tobacco
Illegal Drug Use: Denies Any Illegal Drug Use Currently Using Illegal Drugs (Which:)  Currently Uses Marijuana Currently Using Someone Else's Prescription Medications
□ Formerly Used Illegal Drugs (not currently using) (Which:)
Have you ever abused narcotic or prescription medications?   Yes  No (Which:)
Are you working?   Yes  No Profession? Full Time?  Yes  No

Mark the following conditions/diseases that you have been treated for in the past:  General Medical  Cancer – Type  Diabetes – Diapetosis  Kidney Stones  Kidney Stones  Kidney Stones  Kidney Stones  Urinary Incontinence  Head/Eyes/Ears/Nose/Throat  Gastrointestinal  Bowel Incontinence  Bowel Incontinence  GeRD (Acid Reflux)  Gastrointestinal Bleeding  Hyperthyroidism  Depatitis A  (active / inactive / unsure)  Hepatitis B  (active / inactive / unsure)  Hepatitis C  (active / inactive / unsure)  Hepatitis B  (active / inactive / unsure)  Hepatitis B  (active / inactive / unsure)  Hepatitis C  (active / inactive / unsure)  Hepatitis B  (active / inactive / unsure)  Hepatitis C  Inepatitis C  Inepat	Past Medical History			
Cancer - Type	Mark the following condit	ions/diseases that you have	been treated for in	the past:
Cancer - Type	General Medical	☐ Emphysema / C	OPD	☐ Dialysis/Kidney Problems
Diabetes—Type				-
Head/Eyes/Ears/Nose/Throat   Gastrointestinal   Hepatic   Hepatitis A   Gastrointestinal   Headaches   Bowel Incontinence   Hepatitis A   Gastrointestinal   Hepatic   Hepatitis B   Gastrointestinal Bleeding   Hyperthyroidism   Constipation   Hepatitis B   Gatrointestinal Bleeding   Hyperthyroidism   Constipation   Hepatitis B   Gatrointestinal Bleeding   Hepatitis B   Gastrointestinal Bleeding   Hepatitis B   Gastrointestinal Bleeding   Hepatitis B   Gatrive / unsure)   Hepatitis C   Gatrointestinal Bleeding   Hepatitis B   Gatrive / unsure)   Hepatitis C   Gatrointestinal Bleeding   Hepatitis B   Gatrive / unsure)   Hepatitis C   Gatrive / inactive / unsure)   Hepatitis C   Gatrive /				
Head/Eyes/Ears/Nose/Throat		<del></del>		
Headaches				
Migraines   GERD (Acid Reflux)   (active / inactive / unsure)	·			·
Head Injury	<del>-</del>			-
Hyperthyroidism	_	☐GERD (Acid Refl		
Hypothyroidism		☐Gastrointestinal	Bleeding	•
Glaucoma    Amputation   Amputation   Cardiovascular / Hematologic   Bursitis   Neuropsychological   Alcohol Abuse   Bleeding Disorders   Chronic Low BackPain   Alzheimer Disease   Bleeding Disorders   Chronic Neck Pain   Bipolar Disorder   Bipolar Disorder   High Blood Pressure   Chronic Joint Pain   Depression   Bipolar Disorder   High Cholesterol   Fibromyalgia   Epilepsy   Prescription Drug Abuse   Murmur   Osteoprorsis   Multiple Sclerosis   Paralysis   Paralysis   Poor Circulation   Phantom Limb Pain   Peripheral Neuropathy   Stroke   Rheumatoid arthritis   Schizophrenia   Scroka   Reflex Sympathetic   Dystrophy/CRPS   Other Diagnosed Conditions:   Bladder Incontinence   Reflex Sympathetic   Dystrophy/CRPS   Other Diagnosed Conditions:   Excessive Sweating   Excessive Thirst   Fatigue   Fatigue   Fevers   Insomnia   Low Sex Drive   Night Sweats   Tremors   Unexplained Weight Cans   Unexplained Weight Loss   Hearing Problems   Earas/Nose/Throat/Neck:   Dental Problems   Earaches   Hearing Problems   Insomnia   Low Sex Drive   Dental Problems   Earaches   Hearing Problems   Insomnia   Lears/Nose/Throat/Neck:   Dental Problems   Earaches   Hearing Problems   Insomnia   Lears/Nose/Throat/Neck:   Dental Problems   Earaches   Inseming   Insomnia   Lears/Nose/Throat/Neck:   Dental Problems   Earaches   Inseming   Inseming		Constipation		
Amputation   Amputation   Neuropsychological   Bursitis   Neuropsychological   Alcohol Abuse   Bleeding Disorders   Chronic Low BackPain   Alzheimer Disease   Heart Attack   Chronic Neck Pain   Bipolar Disorder   High Blood Pressure   Chronic Joint Pain   Depression   Epilepsy   Mitral Valve Prolapse   Joint Injury   Prescription Drug Abuse   Murmur   Osteoarthritis   Multiple Sclerosis   Paralysis   Poor Circulation   Phantom Limb Pain   Peripheral Neuropathy   Stroke   Rheumatoid arthritis   Schizophrenia   Schizophrenia   Schizophrenia   Seizures   Pacemaker/Defibrillator   Vertebral Compression   Reflex Sympathetic   Dystrophy/CRPS   Other Diagnosed Conditions:   Pastigue   Fracture   Dystrophy/CRPS   Other Diagnosed Conditions:   Constitutional:   Chills   Difficulty Sleeping   Easy Bruising   Excessive Sweating   Excessive Thirst   Fatigue   Fevers   Tremors   Tremors   Tremors   Premors   Premo	Hypothyroidism			Hepatitis C
Cardiovascular / Hematologic  Onemia  Ocarpal Tunnel Syndrome  Ochronic Low BackPain  Ochronic Neck Pain  Ochronic Joint Pain  Ochronic Joint Pain  Ochronic Joint Pain  Ochronic Joint Injury  Ochronic Joint Albase  Ochronic Joint Injury  Ochrolic Joint Injury  Ochronic Joint Injury  Ochronic Joint Injury  Ochronic Joint	Glaucoma	·		(active / inactive / unsure)
Anemia		•		
Bleeding Disorders  Chronic Low BackPain  Bipolar Disorder  Chronic Neck Pain  Bipolar Disorder  Bepilepsy  Bepilepsy  Befiles Sympathetic  Dystrophy/CRPS  Cother Diagnosed Conditions:  Befiles Sympathetic  Dystrophy/CRPS  Dystrophy/CRPS  Dystrophy/CRPS  Dystrophy/CRPS  Dystrophy/CRPS  Dystrophy/CRPS  D				
Heart Attack  Chronic Neck Pain  Bipolar Disorder  Chigh Blood Pressure  Chronic Joint Pain  Depression  Bipolar Disorder  Depression  Depression  Bipolar Disorder  Depression  Depression  Epilepsy  Mitral Valve Prolapse  Joint Injury  Prescription Drug Abuse  Multiple Sclerosis  Phlebitis  Osteoporosis  Poor Circulation  Phantom Limb Pain  Peripheral Neuropathy  Stroke  Reumatoid arthritis  Schizophrenia  Scoronary Artery Disease  Pacemaker/Defibrillator  Vertebral Compression  Fracture  Paspiratory  Asthma  Genitourinary/Nephrology  Bronchitis  Bladder Incontinence  Review of Systems  Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.  Constitutional:  Chills  Difficulty Sleeping  Excessive Sweating  Excessive Thirst  Fatigue  Fevers  Insomnia  Low Sex Drive  Night Sweats  Tremors  Hearing Problems  Ears/Nose/Throat/Neck:  Dental Problems  Ears/Nose/Throat/Neck:  Dental Problems  Bipolar Discreter  Depression  Depr		•		
High Blood Pressure    Chronic Joint Pain		Chronic Low Bac		
High Cholesterol	_	Chronic Neck Pa		-
Mitral Valve Prolapse  Murmur  Osteoarthritis  Phlebitis  Poor Circulation  Stroke  Pacemaker/Defibrillator  Prescription Drug Abuse  Multiple Sclerosis  Paralysis  Poor Circulation  Phantom Limb Pain  Schizophrenia	☐ High Blood Pressure	Chronic Joint Pai	in 📮	Depression
Murmur  Osteoarthritis  Phlebitis  Osteoporosis  Poor Circulation  Phantom Limb Pain  Stroke  Rheumatoid arthritis  Coronary Artery Disease  Pacemaker/Defibrillator  Practure  Respiratory  Asthma  Genitourinary/Nephrology  Bronchitis  Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.  Constitutional:  Constitutional	High Cholesterol	Fibromyalgia		<b>E</b> pilepsy
Phlebitis Poor Circulation Phantom Limb Pain Peripheral Neuropathy Stroke Rheumatoid arthritis Coronary Artery Disease Pacemaker/Defibrillator Practure Postroke Respiratory Asthma Genitourinary/Nephrology Bladder Incontinence  Review of Systems  Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.  Constitutional: Chills Difficulty Sleeping Excessive Sweating Excessive Sweating Excessive Thirst Dismomia Low Sex Drive Night Sweats Paralysis Peripheral Neuropathy Schizophrenia Schizophrenia Seizures Reflex Sympathetic Dystrophy/CRPS Other Diagnosed Conditions: Other Diagnosed Conditions: Difficulty Sleeping Easy Bruising Easy Bruising Excessive Sweating Excessive Thirst Fatigue Fevers Insomnia Low Sex Drive Night Sweats Tremors Unexplained Weight Gain Unexplained Weight Loss Weakness  Eyes: Recent Visual Changes Glaucoma  Ears/Nose/Throat/Neck: Dental Problems  Earaches  Hearing Problems	Mitral Valve Prolapse	Joint Injury		Prescription Drug Abuse
Poor Circulation Stroke Rheumatoid arthritis Coronary Artery Disease Pacemaker/Defibrillator Respiratory Asthma Bronchitis  Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.  Constitutional: Constitutional: Consider Diagnosed Conditions Constitutional:	□Murmur	Osteoarthritis		Multiple Sclerosis
Poor Circulation Phantom Limb Pain Stroke Rheumatoid arthritis Coronary Artery Disease Pacemaker/Defibrillator Practure Respiratory Asthma Genitourinary/Nephrology Bronchitis  Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.  Constitutional: Consider Chills Consumate Conditions Constitutional: Const	Phlebitis	Osteoporosis		]Paralysis
Stroke Coronary Artery Disease Pacemaker/Defibrillator Practure Practure Prochitis  Genitourinary/Nephrology Bladder Incontinence  Review of Systems  Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.  Constitutional: Excessive Sweating Excessive Sweating Difficulty Sleeping Fevers Insomnia Downser Severs Sev	Poor Circulation	•	ain	Peripheral Neuropathy
Coronary Artery Disease Pacemaker/Defibrillator Pacemaker/Defibrillator  Respiratory Asthma Bronchitis  Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.  Constitutional: Excessive Sweating Excessive Sweating Difficulty Sleeping Excessive Sweating Difficulty Sleeping Excessive Sweating Difficulty Sleeping Di	☐ Stroke	<del>-</del>	_	
Pacemaker/Defibrillator  Respiratory  Asthma  Genitourinary/Nephrology Bronchitis  Review of Systems  Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.  Constitutional:  Chills  Difficulty Sleeping Excessive Sweating Excessive Sweating Excessive Thirst Insomnia Low Sex Drive Night Sweats Tremors  Weakness  Eyes: Recent Visual Changes Glaucoma  Ears/Nose/Throat/Neck: Dother Diagnosed Conditions:  Dother Diagnosed Conditions:  Difficulty Sleeping Fassy Bruising Fastigue Fevers Night Sweats Tremors  Hearing Problems	<del>-</del>			•
Respiratory Asthma Bronchitis Bladder Incontinence  Review of Systems  Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.  Constitutional: Chills Difficulty Sleeping Excessive Sweating Excessive Sweating Discreptive Second Secon	•			
Review of Systems  Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.  Constitutional: Chills Difficulty Sleeping Easy Bruising Excessive Sweating Excessive Thirst Fatigue Fevers Insomnia Low Sex Drive Night Sweats Unexplained Weight Gain Unexplained Weight Loss Weakness  Eyes: Recent Visual Changes Glaucoma  Ears/Nose/Throat/Neck: Dental Problems Earaches Hearing Problems	- r decinater, bentamater		C331011	
Asthma  Genitourinary/Nephrology Bronchitis  Bladder Incontinence  Review of Systems  Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.  Constitutional: Chills Difficulty Sleeping Excessive Sweating Excessive Thirst Fatigue Fevers Insomnia Low Sex Drive Night Sweats Tremors Unexplained Weight Gain Unexplained Weight Loss Weakness  Eyes: Recent Visual Changes Glaucoma  Ears/Nose/Throat/Neck: Dental Problems Earaches	Respiratory	Tracture	_	
Bronchitis  Bladder Incontinence  Review of Systems  Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.  Constitutional: Chills Difficulty Sleeping Easy Bruising Excessive Sweating Excessive Thirst Fatigue Fevers Insomnia Low Sex Drive Night Sweats Tremors Unexplained Weight Gain Unexplained Weight Loss Weakness  Eyes: Recent Visual Changes Glaucoma  Ears/Nose/Throat/Neck: Dental Problems Earaches Hearing Problems	□Asthma	Genitourinary/Ner	hrology	other blaghosea conditions.
Review of Systems  Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.  Constitutional: Chills Difficulty Sleeping Easy Bruising Faxcessive Sweating Excessive Thirst Fatigue Fevers Insomnia Low Sex Drive Night Sweats Tremors Unexplained Weight Gain Unexplained Weight Loss Weakness  Eyes: Recent Visual Changes Glaucoma  Ears/Nose/Throat/Neck: Dental Problems Earaches Hearing Problems	□Bronchitis			
Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.  Constitutional: Chills Difficulty Sleeping Easy Bruising Excessive Sweating Excessive Thirst Fatigue Fevers Insomnia Low Sex Drive Night Sweats Tremors Unexplained Weight Gain Unexplained Weight Loss Weakness  Eyes: Recent Visual Changes Glaucoma  Ears/Nose/Throat/Neck: Dental Problems Earaches Hearing Problems				
Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.  Constitutional: Chills Difficulty Sleeping Easy Bruising Excessive Sweating Excessive Thirst Fatigue Fevers Insomnia Low Sex Drive Night Sweats Tremors Unexplained Weight Gain Unexplained Weight Loss Weakness  Eyes: Recent Visual Changes Glaucoma  Ears/Nose/Throat/Neck: Dental Problems Earaches Hearing Problems	Review of Systems			
Constitutional: Chills Difficulty Sleeping Easy Bruising Excessive Sweating Excessive Thirst Fatigue Fevers Unsomnia Low Sex Drive Night Sweats Tremors Unexplained Weight Gain Unexplained Weight Loss Weakness  Eyes: Recent Visual Changes Glaucoma  Ears/Nose/Throat/Neck: Dental Problems Earaches Hearing Problems		ame that you currently suffa	r from <i>Note: Diggr</i>	nasad sanditians/disagsas shawla
Constitutional:	_ , .	•	i iroin. <i>Note. Diagn</i>	iosea conantions/aiseases snoaia
<ul> <li>Excessive Sweating</li> <li>Excessive Thirst</li> <li>Insomnia</li> <li>Low Sex Drive</li> <li>Night Sweats</li> <li>Tremors</li> <li>Unexplained Weight Gain</li> <li>Unexplained Weight Loss</li> <li>Weakness</li> <li>Eyes: Recent Visual Changes</li> <li>Glaucoma</li> <li>Ears/Nose/Throat/Neck:</li> <li>Dental Problems</li> <li>Earaches</li> <li>Hearing Problems</li> </ul>	be noted under Past Wedi	cai History, above.		
<ul> <li>Excessive Sweating</li> <li>Excessive Thirst</li> <li>Insomnia</li> <li>Low Sex Drive</li> <li>Night Sweats</li> <li>Tremors</li> <li>Unexplained Weight Gain</li> <li>Unexplained Weight Loss</li> <li>Weakness</li> <li>Eyes: Recent Visual Changes</li> <li>Glaucoma</li> <li>Ears/Nose/Throat/Neck:</li> <li>Dental Problems</li> <li>Earaches</li> <li>Hearing Problems</li> </ul>	Constitutional:	Chills	☐ Difficulty Sleepin	g
□Insomnia       □ Low Sex Drive       □ Night Sweats       □ Tremors         □Unexplained Weight Gain       □ Unexplained Weight Loss       □ Weakness         Eyes:       □ Recent Visual Changes       □ Glaucoma         Ears/Nose/Throat/Neck:       □ Dental Problems       □ Earaches       □ Hearing Problems				
□Unexplained Weight Gain       □ Unexplained Weight Loss       □ Weakness         Eyes:       □ Recent Visual Changes       □ Glaucoma         Ears/Nose/Throat/Neck:       □ Dental Problems       □ Earaches       □ Hearing Problems	_		•	
Eyes: Recent Visual Changes Glaucoma  Ears/Nose/Throat/Neck: Dental Problems Earaches Hearing Problems			_	- Temors
Ears/Nose/Throat/Neck: Dental Problems Earaches Hearing Problems		_ :		
-	Eyes: Recent Visual Chang	ges   Glaucoma		
<del>-</del>	Fars/Nose/Throat/Neck·	Dental Problems	□ Faraches	☐ Hearing Problems

Cardiovascular:  Fainting Shortness of Breath	☐ Bleeding Disorder ☐ High Blood Pressure During Sleep	<ul><li>Chest Pain</li><li>Irregular Heartbeat</li><li>Swelling in the Feet</li></ul>	<ul><li>Deep Vein Thrombosis</li><li>Lightheadedness</li></ul>
Respiratory: Shortness of Breath of	□Cough on Exertion/Effort	<ul><li>Wheezing</li><li>Shortness of Breath at</li></ul>	□ Pulmonary Embolism : Rest
Gastrointestinal: Coffee Ground Appea Hernia	<ul><li>Abdominal Cramps</li><li>Irance in Vomit</li><li>Vomiting</li></ul>	□ Acid Reflux □ Dark and Tarry Stools	☐ Constipation☐ Diarrhea
Musculoskeletal:  Joint Swelling	<ul><li>□ Back Pain</li><li>□ Muscle Spasms</li></ul>	□ Joint Pain □ Neck Pain	☐ Joint Stiffness
Genitourinary/Nephrolo Decreased Urine Flow		□Blood in Urine □Flank Pain	Painful Urination
Neurological:  Headaches	□Carpal Tunnel Syndro □Numbness/Tingling	me Instability When W Dizziness Tremors	′alking □Seizures
Psychiatric: Suicidal Thoughts	<ul><li>□ Depressed Mood</li><li>□ Suicidal Planning</li></ul>	☐Feeling Anxious	□Stress Problems
Medical History an	d Consent for Treat	ment	
I certify that the above	. :	1	
i certify that the abov	e information is accurate	e, complete and true.	
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