UTHealth
The University of Texas
Health Science Center at Houston

NEW PATIENT HISTORY
Mark L. Prasarn, M.D.

Date: _____ Name:_____ Age:_____

Height:_____ Weight:_____ Pharmacy:_____ Phar. Phone#:_____

Primary Care M.D._____ Referring M.D.:_____

What is your Chief Complaint?

- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Lower Back Pain
- ☐ Right Leg Pain
- ☐ Left Leg Pain
- ☐ Pain in Both Legs
- ☐ Right Arm Pain
- ☐ Left Arm Pain
- ☐ Pain in Both Arms
- ☐ Scoliosis
- ☐ Other – Specify

When did the pain start?

- ☐ Within the last week
- ☐ Within the last month
- ☐ Within the last year
- ☐ More than a year ago

What makes the pain better?

- ☐ Sitting
- ☐ Lying Down
- ☐ Walking
- ☐ Standing
- ☐ Leaning Forward on Shopping Cart
- ☐ Nothing in Particular

What aggravates the pain?

- ☐ Walking
- ☐ Standing
- ☐ Sitting
- ☐ Lying Down
- ☐ Bending Forward
- ☐ Bending Backwards
- ☐ Twisting
- ☐ Lifting
- ☐ Trying to Play Sports
- ☐ Nothing in Particular

Is this a result of a Work Injury? Yes / No If yes, Date of Injury:_____
Is this a result of an Auto Injury? Yes / No If yes, Date of Injury:_____
Do you have an attorney? Yes / No
Have you had any diagnostic studies? (i.e., X-rays, MRI, EMG, Myelogram, Discogram, Bone Scan)
If so, please list all studies and the most recent date:_____
_____

Have you tried any of the following for your pain?

- ☐ Nothing
- ☐ Physical Therapy
- ☐ Active Exercise
- ☐ TENS Unit
- ☐ Heat
- ☐ Cold
- ☐ Manipulation
- ☐ Spinal Injections
- ☐ Surgery
- ☐ Medication
- ☐ Chiropractor
- ☐ Other – Specify:_____

Were any helpful in relieving your pain?
If so, which ones:_____
_____
_____

Past Medical History: (Please circle all that apply)

HIV	Diabetes	High Blood Pressure	Heart Attack	COPD/Emphysema
Thyroid	Asthma	Coronary Artery Disease	Stroke/TIA	Hepatitis A / B / C
Cirrhosis	Lupus	Osteopenia/Osteoporosis	Depression	Tuberculosis
Seizures	Reflux	Kidney Disorder/Failure	High Cholesterol	Osteoarthritis
Pacemaker	Gout	Congestive Heart Failure	Bleeding Disorders	Rheumatoid Arthritis
Ulcers	Blood Clot	Peripheral Artery Disease	Arrhythmia	Sleep Apnea

Cancer, type:_____

Past Surgical History

Type of Surgery	Name of Doctor	Date	Name of Hospital

MEDICATIONS: Please list all your current medications, including dosage and how often you take it. Please include all over-the-counter medications, herbal supplements, etc.

MEDICATION	STRENGTH	HOW OFTEN TAKEN?

ALLERGIES:

Do you have any allergies to medications? **Yes** ☐ **No** ☐

If yes, please list:

_____

_____

_____

Family Medical History: (please circle any that apply)

Chest Pain	Heart Attack	Congestive Heart Failure	Stroke/TIA	High Blood Pressure
Diabetes	Blood Clot	Bleeding Disorder	Cirrhosis	Kidney Disorder/Failure
Lupus	Reflux	COPD/Emphysema	Asthma	Hepatitis A / B/ C
Seizures	Thyroid	Rheumatoid Arthritis	Osteoarthritis	Osteopenia/Osteoporosis
Depression	Gout	Tuberculosis	Ulcers	Osteomyelitis (bone infection)

Cancer, type:_____

Has anyone in your family ever been diagnosed with back/neck problems? **Yes / No**

Has anyone in your family ever had back or neck surgery? **Yes / No**

Substance Use: (please address all that apply)

		Type of	How often	Date Started	Date quit
Tobacco	Yes / No				
Alcohol	Yes / No				
Illicit Drugs	Yes / No				

History of Substance or Alcohol Abuse Yes / No

If Yes, which substance?_____ Date Quit?_____

Current Medical Problems: (please circle all that apply)

Headache	Blurry vision	Loss of Bowel Control	Fever	Pain at Night
Hoarseness	Dizziness	Numbness/Tingling	Cough	Leg Swelling
Chest Pain	Palpitations	Loss of Bladder Control	Hay Fever	Depression
Painful Urination	Bruise Easily	Irregular Heart Beat	Chills	
Weight Loss	Heartburn	Shortness of Breath	Frequent Falls	

The following lines represent pain of increasing intensity from "no pain" to "worst possible pain." Draw ONE vertical mark or each of the lines below to best describe:

Your pain right now:

No Pain ——— Worst Possible Pain

The average intensity of your pain this week:

No Pain ——— Worst Possible Pain

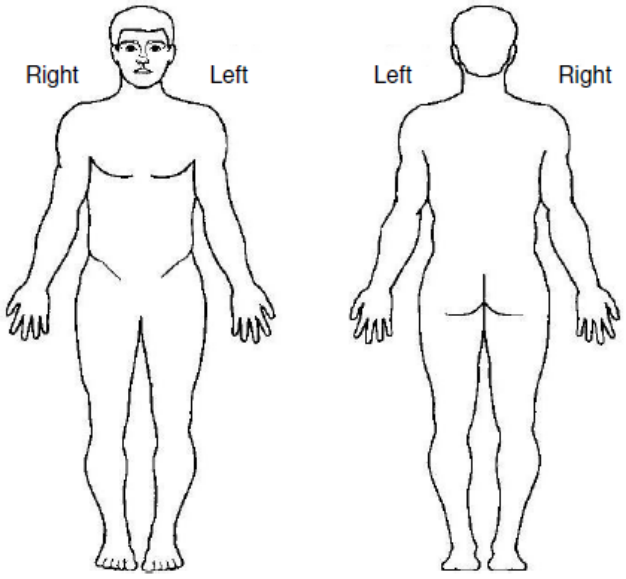
Your pain at its worst:

No Pain ——— Worst Possible Pain

Your pain at its least:

No Pain ——— Worst Possible Pain

On the drawing below, please shade the area where you currently experience pain.



Are you currently working?

- ☐ Regular employment – no restrictions
- ☐ Full time with restrictions
- ☐ Part time by choice
- ☐ Part time for medical reasons
- ☐ Retired by choice
- ☐ Retired for medical reasons
- ☐ Student
- ☐ Unemployed – Looking for work with no restrictions
- ☐ Unemployed – Looking for light duty
- ☐ Unemployed
- ☐ Currently not working for medical reasons
- ☐ Homemaker
- ☐ Self-employed
- ☐ Other – Please specify _____

Do you participate in sports or athletics?

- ☐ Regularly 3x/week
- ☐ Regularly 2x/week
- ☐ Regularly 1x/week
- ☐ Irregularly
- ☐ None
- ☐ medical problems prevent

OFFICE USE ONLY

Height:_____ Weight:_____

Blood Pressure:_____ Pulse: _____

The following questions are designed to give the doctor information as to how your spine (back) pain has affected your ability to manage in everyday life. **Please answer every section, and choose only the <u>one</u> box that applies to you.** Sometimes two of the statements in one section seem right, but please just mark the box that most closely describes your problem.

Pain Intensity

- ☐ I can tolerate the pain I have without having to use pain medications.
- ☐ The pain is bad, but I manage without having to take pain medication.
- ☐ Pain medication provides me with complete relief from pain.
- ☐ Pain medication provides me with moderate relief from pain.
- ☐ Pain medication provides me with little relief from pain.
- ☐ Pain medication has no effect on my pain.

Personal Care

- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally, but it causes me extra pain.
- ☐ It is painful to take care of myself and I am slow and careful.
- ☐ I need help, but I am able to manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

Lifting

- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights, but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned, (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking for more than 1 mile.
- ☐ Pain prevents me from walking for more than 1/2 mile.
- ☐ Pain prevents me from walking for more than 1/4 mile.
- ☐ I can only walk using crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Standing

- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want, but it increases my pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than 1/2 hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using pain medication
- ☐ Even when I take pain medication, I sleep less than 6 hours.
- ☐ Even when I take pain medication, I sleep less than 4 hours.
- ☐ Even when I take pain medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

Social Life

- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but increases my level of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of pain.

Traveling

- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere, but it increases my pain.
- ☐ My pain restricts my travel over 2 hours.
- ☐ My pain restricts my travel over 1 hour.
- ☐ My pain restricts my travel to short necessary journeys under 1/2 hour.
- ☐ My pain prevents all travel except for visits to the physician/therapist or hospital.

Employment / Homemaking

- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain. But I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties. But pain prevents me from performing more physically stressful activities.
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.