# Advanced Pain Medicine

www.advancedpainmedicine.com

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**Clinic Locations:**

**MAIN OFFICE**
**7000 Stonewood Drive**
**Wexford, PA 15090**

**1000 Higbee Dr. Suite D207**
**Bethel Park, PA 15102**

**One Hospital Way**
**Butler, PA 16001**

**545 Rugh Street**
**Greensburg, PA 15601**

**2566 Haymaker Rd**
**Monroeville, PA 15146**

**1009 Beaver Grade Rd**
**Moon Twp, PA 15108**

**356 Freeport St.**
**New Kensington, PA 15068**

**500 Lewis Run Road**
**West Mifflin, PA 15122**

**333 State Street**
**Erie, PA 16507**

**500 Market Street**
**West Bridgewater, PA 15009**

**3000 Mon Health Medical Park Dr.**
**Morgantown, WV 26505**

**2915 Wilmington Road**
**New Castle, PA 16105**

**100 Trich Dr**
**Washington, PA 15301**

**647 N. Broad St Ext. Suite 204**
**Grove City, PA 16127**

**235 Ellwood-Zelienople Rd**
**Ellport, PA 16117**

## How does our process work?

When a patient first visits, us a comprehensive examination is conducted, and their medical history is thoroughly reviewed. This allows our specialists to accurately diagnose or confirm the patient's specific condition. Subsequently, the physician specialists and clinical staff collaborate to develop a personalized treatment plan that aligns with the patient's needs and goals.

In our clinic, we provide a range of pain management procedures tailored to meet the specific needs of each patient. The treatment plan may commence with a series of epidural steroid injections, then according to the degree of your pain relief, may proceed with nerve blocks and diagnostic procedures in order to identify the point of origin of the patient's pain. These treatments are part of a comprehensive plan developed by our healthcare team to ensure effective pain management and improve the patient's quality of life. A customized pain medication regimen is included in the plan to address the individual's specific needs. Throughout the treatment, monitoring the patient's body's response is crucial for diagnosing the underlying cause of pain. Therefore, it is essential to adhere to the plan, even if the patient perceives the procedures as ineffective.

## Key Procedures Include:

| | |
|---|---|
| ⇒ **Epidural Steroid Injections** | used to provide pain relief from inflammation and pain of the spine |
| ⇒ **Facet Nerve Blocks** | diagnostic procedures that help locate the source of spine pain |
| ⇒ **Rhizotomy** | involves lesioning of the nerve roots to reduce pain after successful nerve blocks |
| ⇒ **Kyphoplasty** | procedure to alleviate pain from vertebral compression fractures by stabilizing the bone |
| ⇒ **Spinal Cord Stimulator** | device implanted near the spine to to send electrical signals that mask pain signals to the brain |
| ⇒ **Intrathecal Pump Pump** | pumps that deliver pain medication directly to the spinal cord to manage chronic pain |
| ⇒ **Intracept Procedure** | minimally invasive procedure to treat chronic spinal pain by targeting the nerve that innervates the disc and bone |

# PATIENT BRIEF HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. It will be entered into our system to ensure the best possible care for you.

**Patient's Last Name _____First _____ MI _____**

**Sex** ☐ Male ☐ Female **Date of Birth: _____ Social Security #:_____**
**Name of Primary Care Physician: _____Phone # of PCP:_____**
**Name of Referring Physician: _____Phone # of referring: _____**
**Name of Emergency Contact: _____Phone # _____**
**Pharmacy Preference (include location): _____Phone #_____**

**PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:**

| Name of Medication | Dosage | How Often Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**MEDICATION ALLERGIES**

| Name of Medication | Type of Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Latex Allergy: □Yes □No** **IV Contrast Allergy: □Yes □No**

**SURGERIES**:_____
_____
_____
_____
_____

**RECENT DIAGNOSTIC TESTS, MRI'S, X-RAY'S, EMG'S (Please indicate when/where these were performed):**
_____
_____
_____

Have you ever had any problems with **anesthesia** (being numbed or put to sleep)? □Yes □No
Have you ever been hospitalized for **non-surgical** reasons? □Yes □No
If yes, list reasons for hospitalizations _____
_____

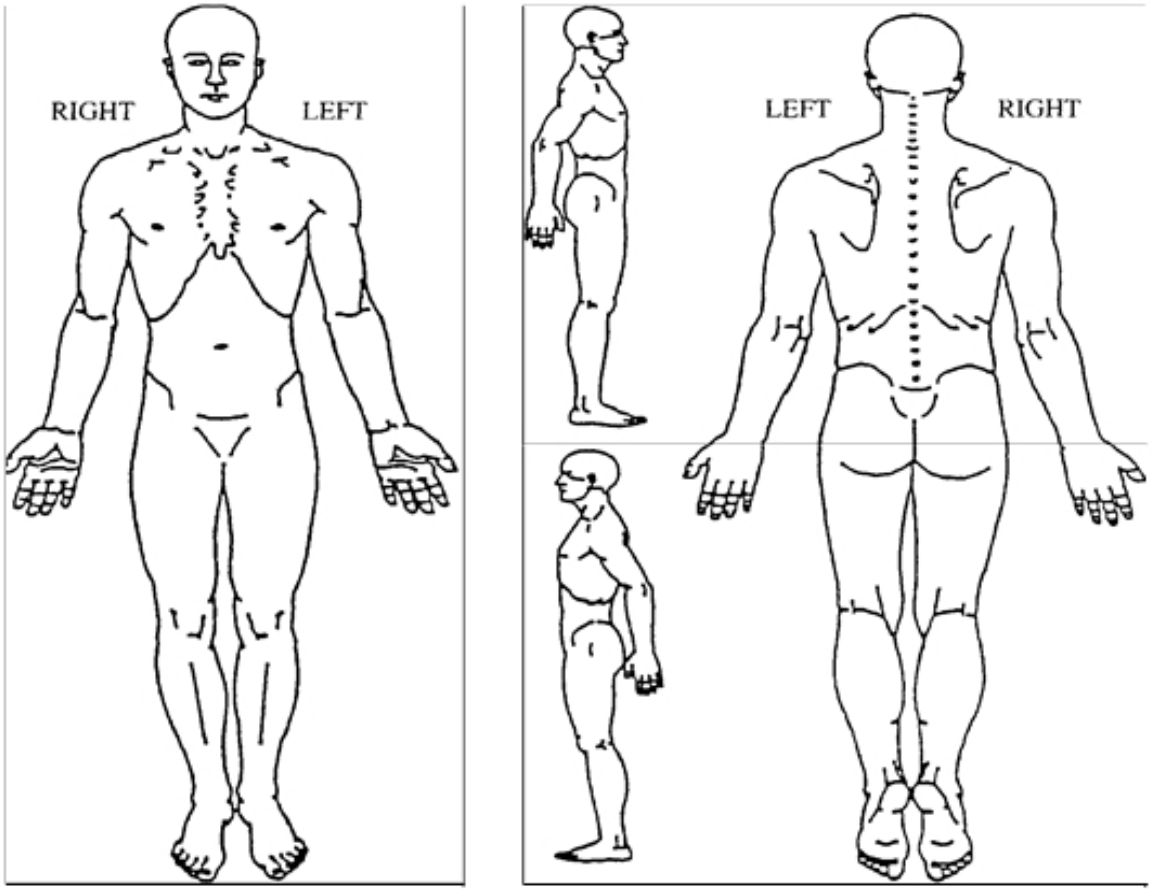
# Advanced Pain Medicine

7000 Stonewood Drive, Suite 151, Wexford, PA 15090
Phone: (724) 933-0300 Fax: (724) 993-0456

Name: _____

1. What is the main complaint for which you are seeking treatment at Advanced Pain Medicine?

2. On the diagram, shade in the areas where you feel pain. Put an "X" on the area that hurts the most.




3. How long have you had the pain problem you are currently experiencing (in months and years)?

4. What caused your current pain?

5. Describe the characteristics of your pain (circle each that describes your pain).

| | | |
|---|---|---|
| Piercing | Throbbing | Numbing |
| Stabbing | Cramping | Itching |
| Shooting | Aching | Tingling |
| Burning | Stinging | None |
| Grinding | Squeezing | |

6. How often do you have pain?
   a. ☐ Constantly (80-100% of the time)
   b. ☐ Nearly constantly (50-80% of the time)
   c. ☐ Intermittently (25-50% of the time)
   d. ☐ Occasionally (less then 25% of the time)

7. What kinds of things make your pain feel better? (example: sitting, sleeping, etc.)

8. What kinds of things make your pain feel worse? (example: standing, lifting, etc.)

9. Please indicate which treatments you have tried in the past. Choose the corresponding number indicating the relieving effect on your pain**: <u>PLEASE INCLUDE THE DATE AND DURATION.</u>**

**1 – Worsened Pain  2 – No Relief  3 – Partial Relief  4 – Complete Relief**

| | DATE | | DATE | | DATE |
|---|---|---|---|---|---|
| ___Acupuncture | _____ | ___SI joint injection | _____ | ___Spinal Cord Stimulator | _____ |
| ___Chiropractor | _____ | ___Nerve Block | _____ | ___TENS (Elect Stim) | _____ |
| ___Epidural Steroid Inj. | _____ | ___Physical Therapy | _____ | ___Traction | _____ |
| ___Exercise | _____ | ___Psychotherapy | _____ | ___Facet Rhizotomy | _____ |
| ___Hot/Cold Tmts | _____ | ___Surgery | _____ | | |

10. Please indicate all of the medications you have tried for your current pain complaint. Indicate the amount of relief you experienced with each medication by writing the corresponding number below. Any medication you have not previously tried leave blank.

**1 – Worsened Pain  2 – No Relief  3 – Partial Relief  4 – Complete Relief**

| ☐ **Anti-Neuropathic** | ☐ **Non-Steroidals** | ☐ **Narcotics** | ☐ **Tranquilizers** |
|---|---|---|---|
| ___Neurontin (gabapentin) | ___Aspirin | ___Vicodin | ___Ambien |
| ___Lyrica (pregabalin) | ___Aleve | ___Percocet | ___Robaxin |
| ___desipramine | ___Etodolac (lodine) | ___OxyContin | ___Valium |
| ___Elavil (amitriptyline) | ___Advil (ibuprophen) | ___Opana | ___Xanax |
| ___Topamax | ___Mobic | ___Butrans | ___Flexeril |
| ___Cymbalta | ___Relafen | ___Morphine | ___Soma |
| ___Other: | ___Celebrex | ___Ultram | ___Zanaflex |
| | ___Other: | ___Nucynta | ___Lunesta |
| | | ___Fentanyl Patch | ___Other: |
| | | ___Suboxone | |
| | | ___Methadone | |
| | | ___Other: | |

11. Have any other health care professionals and/or specialists been involved in the evaluation and treatment of our current pain? **If so, please state their name, specialty, and/or their practice name if known.**

12. Please list your goals of treatment and pain relief while a patient of Advanced Pain Medicine:

## Past Medical History

Have you had any of the following health problems? (please circle all that apply)

| | | |
|---|---|---|
| Neurologic Disorder | Obstructive Sleep Apnea | Muscle Disease |
| Seizures or Epilepsy | Asthma or Wheezing | Arthritis |
| Transient Ischemic Attack/Stroke | Chronic Cough | Blood Disorder/Anemia |
| High Blood Pressure | Stomach Ulcer | Blood Clots: Pulmonary/DVT |
| Heart Attack | Liver Disease/Hepatitis/Cirrhosis | Cancer |
| Heart Rhythm Disorder | Diabetes or High Blood Sugar | Depression/Anxiety |
| Valvular Heart Disease | Thyroid Disease | Mania |
| Lung Disease | Kidney Disease/Kidney Stones | Suicidal Tendency |

## Review of Symptoms

Please circle the symptoms listed below that you have experienced in the past few months.

**CONSTITUTIONAL:** Fever Chills Weight Change Change in appetite

**CARDIOVASCULAR:** Chest Pain Palpitations Irregular Heart Beat Difficulty breathing when lying down

**RESPIRATORY:** Shortness of Breath Cough Wheezing

**GASTROINTESTINAL:** Nausea Vomiting Abdominal Pain Change in bowel habits Black Stools

**GENITOURINARY:** Frequent urination Urinary incontinence Painful urination

**MUSCULOSKELETAL:** Muscle Pain Joint Pain Muscle Weakness

**SKIN:** Rashes Bruising easily Ulcers Itching

**NEUROLOGICAL:** Headaches Dizziness Seizures Numbness Tingling Weakness

**PSYCHIATRIC:** Anxiety Depression Difficulty sleeping

**HEMATOLOGIC/LYMPHATIC:** Bleeding tendency Frequent infections

***Explain any above circled items here**:*

## Social History

1. Current or previous occupation:_____
2. Present employment status:

   ☐Full Time ☐Unemployed ☐Leave of Absence ☐Student

   ☐Part Time ☐Retired ☐Homemaker

   If you are working full- or part-time, when did you return to work? (Date):_____
3. What was your last day of work (if not currently working)? _____
4. Substance intake per day: (Please indicate how often you use or consume the following)
   a. Caffeine (coffee, tea, cola, etc.)_____
   b. Nicotine (Cigarettes, cigar, pipe, smokeless tobacco, etc)_____
5. Your present use of alcoholic beverages is (choose one):

   ☐None ☐Occasionally (less than 1 drink per week) ☐Daily

   ☐Rarely(less than one drink per month) ☐Regularly (drink 2-3 times per week)

6. Have you ever used any of the following drugs? Choose all that apply.

**PLEASE INDICATE WHEN LAST USED** in the space provided.

☐Marijuana _____ ☐Cocaine _____ ☐Other Street Drugs _____

☐Amphetamines _____ ☐Heroin _____ ☐ None of these

7. Marital Status (choose one):

☐Single ☐Divorced ☐Widowed

☐Married ☐Separated ☐Remarried

8. Number of children:_____

9. Present living situation:

☐Alone ☐With Children ☐With friend

☐With Spouse ☐With Parents ☐With other family members

10. Education (check the highest grade/degree completed):

☐Less than 8th grade ☐Some high school ☐Some college ☐Advanced degree

☐Completed 8th grade ☐High school graduate ☐College graduate

## Family Medical History

1. Please list any chronic pain conditions that are present in your family:

2. Is there any family history of anesthesia problems? ☐Yes ☐No

**Signature of Patient:** _____ **Date Completed:** _____

**If form has been completed by someone *other* than the patient, please print and sign name below:**

Name: _____

Signature:_____

Relationship to Patient:_____

Signature of Reviewer: _____ M.D. / PA-C