PAIN MEDICINE ASSOCIATES PMA
Patient Pain Data Questionnaire (PPDQ)

Date: _____

Last Name	
First Name	
Referring MD	
SS #	DOB

YOUR BACKGROUND

1. How long have you been experiencing your pain? _____
2. Is your pain ☐Constant ☐Intermittent ☐Varies in intensity?
3. How has the intensity of your pain changed since it first began?
   ☐Increased ☐Decreased ☐Stayed the same
4. Is your pain the result of an accident or injury? ☐Yes ☐No
   If yes, date of injury _____
   If yes, is this a Workman's Comp. Claim? ☐Yes ☐No
5. Is there pending litigation concerning your pain? ☐Yes ☐No
6. Do you currently work? ☐Yes ☐No

   If no, date last worked: _____
7. Are you rated as disabled because of your pain? ☐Yes ☐No
8. Are you applying for disability because of pain? ☐Yes ☐No
9. Do you consider yourself disabled by pain? ☐Yes ☐No

FACTORS AFFECTING YOUR PAIN

How do the following activities or therapies affect your pain?

	Increase	Decrease	No Effect	Not Tried
Activities				
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying Down	☐	☐	☐	☐
Shifting Positions	☐	☐	☐	☐
Bending Forward	☐	☐	☐	☐
Bending Backward	☐	☐	☐	☐
Twisting	☐	☐	☐	☐
Cough / Sneeze	☐	☐	☐	☐
Therapies				
Resting	☐	☐	☐	☐
Pain Medicines	☐	☐	☐	☐
Steroids by mouth	☐	☐	☐	☐
Physical Therapy	☐	☐	☐	☐
Chiropractic	☐	☐	☐	☐
Massage	☐	☐	☐	☐
Surgery	☐	☐	☐	☐
Injections, trigger points	☐	☐	☐	☐
Injections, epidurals	☐	☐	☐	☐
Injections, other types	☐	☐	☐	☐
TENS unit	☐	☐	☐	☐

Your Exercise Tolerance

Please indicate the most active thing you do **now** and what you used to do **before** developing your painful condition.

	Now	Before
Nothing	☐	☐
Walking	☐	☐
Go to Mailbox	☐	☐
Go Shopping	☐	☐
Drive in car	☐	☐
Housework	☐	☐
Yard work	☐	☐
Jog / Run	☐	☐
Sports	☐	☐

CONSEQUENCES OF PAIN*

Do you feel your pain has ***caused***, or caused you to ***think about***, any of the following. Check ***neither*** if not applicable or no effect.

	Caused	Think About	Neither
Difficulty performing Activities of Daily Living	☐	☐	☐
Inability to perform Activities of Daily Living	☐	☐	☐
Loss of control of bowel	☐	☐	☐
Loss of control of bladder	☐	☐	☐
Difficulty falling asleep	☐	☐	☐
Awaken from sleep	☐	☐	☐
Restless sleep	☐	☐	☐
Inability to sleep	☐	☐	☐
Decreased social activity	☐	☐	☐
Decreased family interaction	☐	☐	☐
Problems with relationship(s)	☐	☐	☐
Decreased desire for sex	☐	☐	☐
Feeling depressed	☐	☐	☐
Diagnosis of depression	☐	☐	☐
Irritable	☐	☐	☐
Feelings of anger	☐	☐	☐
Feelings of suicide	☐	☐	☐

*Please note, although the above consequences may be related to your pain, many of these are psychosocial consequences and are beyond the scope of treatment available in our clinic.

Doctor's / Reviewer's Comments:

Verification: Date:

PAIN MEDICINE ASSOCIATES PMA
Patient Medical Data Questionnaire (PMDQ)

Date: _____

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Last Name	
First Name	
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Medical History / Review Of Systems

How do you consider your **overall health**?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Females: Are you **pregnant**? ☐ No ☐ Yes ☐ Maybe

Date of last menstrual period _____

Please check any of the following that you currently have or have recently had:

1. General

☐ Night fever/chills ☐ Unexplained weight gain / loss
☐ Frequent nausea ☐ Change in appetite ☐ General weakness
☐ General fatigue ☐ Fibromyalgia ☐ Lupus

2. Integument

☐ Skin cancer ☐ Skin sores ☐ Skin rash
☐ Hair changes ☐ Change in Skin appearance
☐ Easy bruising

3. HEENT

☐ Change in vision ☐ Eye discharge ☐ Blindness/glaucoma
☐ Nasal discharge ☐ Nasal bleeding ☐ Sinusitis
☐ Hearing loss ☐ Mouth sores ☐ Sore throat

4. Cardio-Vascular

☐ Heart attack ☐ Cardiac arrest ☐ High blood pressure
☐ Heart failure ☐ Skipped beats ☐ Palpitations
☐ Arrhythmia ☐ Heart murmur ☐ Valve disease
☐ Heart surgery ☐ Rheumatic fever ☐ Angina chest pain

5. Respiratory

☐ Bronchitis ☐ Asthma ☐ Emphysema
☐ Wheezing ☐ Pneumonia ☐ Shortness of breath
☐ Tuberculosis ☐ Chronic cough ☐ Lung cancer

6. Nervous System

☐ Anxiety disorder ☐ Depression ☐ Tension headaches
☐ Migraines ☐ Nervous tension ☐ Nervous exhaustion
☐ Chronic insomnia ☐ Numbness ☐ Paralysis
☐ Weakness ☐ Fainting ☐ Blackout spells
☐ Brain disease ☐ Alzheimer's dz ☐ Spinal cord dz
☐ Meningitis ☐ Epilepsy ☐ Seizures
☐ Polio

7. Gastro-Intestinal

☐ Jaundice ☐ Hepatitis ☐ Liver disease
☐ Ulcers ☐ Hiatal Hernia ☐ Chronic reflux
☐ Irritable bowel ☐ Diarrhea ☐ Constipation
☐ Crohn's disease ☐ Ulcerative colitis ☐ Polyps
☐ Blood in stools ☐ Black/tarry stools ☐ Colon cancer
☐ Gallbladder dz ☐ Loss of bowel control

8. Endocrine

☐ Diabetes ☐ Thyroid disease ☐ Pancreatitis

9. Musculoskeletal

☐ Osteoporosis ☐ Osteo-Arthritis ☐ Rheumatoid arthritis
☐ Bursitis ☐ Osteomyelitis ☐ Artificial joints

10. Genitourinary

☐ Kidney stones ☐ Kidney infection ☐ Kidney failure
☐ Dialysis ☐ Bladder infection ☐ Loss of control

11. Hematological (blood)

☐ Take blood thinning medications ☐ Easy bleeding
☐ Blood clots ☐ Abnormal clotting ☐ Hemophilia
☐ Anemia ☐ Sickle cell disease ☐ Sickle cell trait
☐ Swollen glands or lymph nodes

12. Other medical problems not listed: (please list)

Allergies

Are you **allergic** to **shellfish**? ☐ Don't know ☐ No ☐ Yes
Are you **allergic** to **I.V. Dye**? ☐ Don't know ☐ No ☐ Yes
Are you **allergic** to any **other medications**? ☐ No ☐ Yes, **list**:

Surgical History

Have you ever had any **surgery**? ☐ No ☐ Yes, list:
(please list most recent surgeries, including date or approximate date)

Have you ever had difficulty with **anesthesia**? ☐ No ☐ Yes:
☐ Difficult/slow to wake up ☐ Weakness waking up
☐ High fever ☐ Nausea and/or vomiting

Patients: please do not write here.

Verification: _____ Date: _____

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Date: _____

SOCIAL HISTORY:

1. Do you **smoke**? ☐No ☐Yes, _____ packs per day.
   If no, did you **ever** smoke? ☐No ☐Yes, date quit_____
2. Do you **drink**? ☐No ☐Yes, _____ drinks / beers per day.
   If no, did you ever drink? ☐No ☐Yes, date quit_____
   Do you, or did you ever, have a drinking problem? ☐No ☐Yes
   If yes, have you sought professional treatment? ☐No ☐Yes
3. Do you use any other **recreational drugs**? ☐No ☐Yes
   If yes: ☐Cocaine ☐Marijuana ☐Other: _____
4. What is your highest level of **education**?
   ☐Grade School ☐High School ☐College ☐Grad Sch.
5. Are you: ☐Married ☐Divorced ☐Single
6. Do you **live with**: ☐Spouse ☐Companion ☐Friend ☐Family member, or ☐Alone
7. How many people live in your **household**? _____
8. How many **children** do you have: _____ girls _____ boys
   Children's ages: girls: _____ boys _____
   Number of children living at home: _____ ages _____
9. Your **occupation**: _____
10. Spouse's/companion's occupation: _____
11. Are you **disabled**? ☐No ☐Yes
    Is your spouse/companion disabled? ☐No ☐Yes

Family History

Please check if any **blood relative** of yours have, or have a history of, any of the following:

	Mother	Father	Bro/Sis	Grandparent
High blood pressure	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐
Heart failure	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐
Lung cancer	☐	☐	☐	☐
Chronic pain	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Anxiety disorder	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Mini stroke (TIA)	☐	☐	☐	☐
Irritable bowel	☐	☐	☐	☐
Intestinal polyps	☐	☐	☐	☐
Colon cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐

Patients: please do not write in this space	
Reviewer's Comments:	
	Verification: Date:

Date: _____ PAIN MEDICINE ASSOCIATES, P.C. Name: _____

Drug Information Sheet

Please Complete and bring with you to your appointment*

Drug Name	Prescription Strength	How often/how is dose taken?	Prescribed By?
Example: Tylenol	500mgs.	2 times a day by mouth	Dr. Jones

Nurse Signature: _____

Include prescriptions, over-the-counters, herbals and vitamin/mineral/dietary supplements