CEDARS-SINAI MEDICAL CENTER.
THE PAIN CENTER

PAIN EVALUATION
HEAD AND NECK

PATIENT I.D.

Date: _____ Arrival Time: _____

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Daytime Phone # _____ Alternate Phone # _____

Primary language: _____ Height: ____ Weight: ____ Dominant Hand: ❑ Right ❑ Left

OTHER / REFERRING DOCTORS: please list the Doctors you would like records sent to

Name of Doctor	Specialty	Phone Number	Fax	Address

UNDERSTANDING YOUR CURRENT PAIN: *(Reason for visit)*

Describe in ***your own words*** the pain problem(s) you would like help with:

_____

_____

_____

Is nausea associated with your pain? ❑ Yes ❑ No

Is vomiting associated with your pain? ❑ Yes ❑ No

Does your pain increase with bright lights? ❑ Yes ❑ No

Does your pain increase with loud noises? ❑ Yes ❑ No

Does physical activity make your pain: (check one) ❑ better ❑ worse ❑ no change

Do you get an aura (flashing lights, zigzags, blindness, smells)? ❑ Yes ❑ No

*If Yes, (describe): _____

Does your pain wake you from sleep? ❑ Yes ❑ No

Does your pain keep you from falling asleep? ❑ Yes ❑ No

Do any of your family members have the same or similar pain problem? ❑ Yes ❑ No

Do any of these occur with your pain? (check all that apply)

❑ Redness of the eye(s) ❑ Eyelid drooping

❑ Tearing of the eye(s) ❑ Nasal stuffiness ❑ Facial sweating

Do you have difficulty opening or closing your mouth? ❑ Yes ❑ No

Do you hear clicking or popping in your jaw joints? ❑ Yes ❑ No

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UNDERSTANDING YOUR CURRENT PAIN: *(Cont'd)*

Is your pain: ❑ Continuous or ❑ Intermittent*?

*If your pain is **intermittent** how often does it occur?

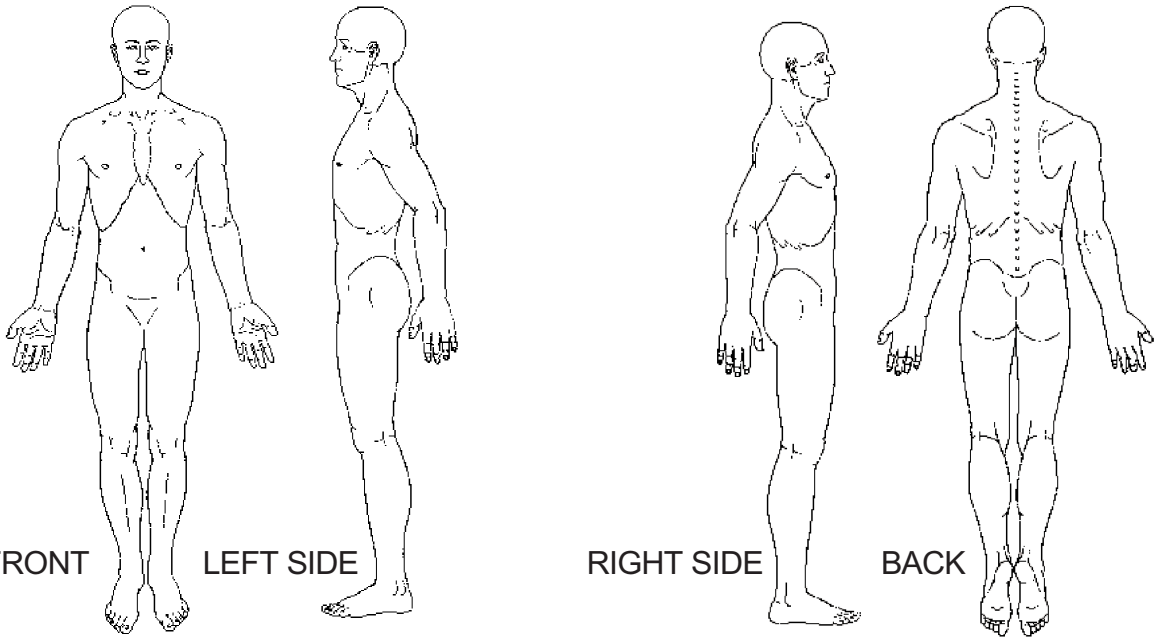
❑ Several times a day ❑ Several times per week ❑ Less than once per week
❑ Once per day ❑ Once per week ❑ Never
❑ Other _____

How long does your pain last? ❑ None ❑ Seconds ❑ Minutes ❑ Hours ❑ Days ❑ Weeks

Circle a number below to indicate your **usual** pain intensity over the past week:

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild pain		Moderate pain			Severe pain			Most intense pain imaginable

Please mark area(s) of pain with an (X):



What makes the pain ***WORSE?*** Be Specific.

_____

_____

What makes the pain ***BETTER?*** Be Specific.

_____

_____

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CURRENT MEDICATIONS:

List all medications you are currently taking for medical and pain problems including prescribed, over-the-counter, herbs, vitamins. Do not bring your medicines to the clinic unless you have a question to discuss with the physicians.

Name	Pill Strength	# of times taken per day	Doctor who prescribed	Date started

Pharmacy, name, phone, and FAX: _____

HISTORY OF YOUR PAIN:

When did your pain start? _____

When did your pain become a problem? _____

What event(s) led to your present pain?

❑ Accident ❑ Other injury ❑ Other disease ❑ No obvious cause

❑ Cancer ❑ Following an operation ❑ Other: _____

What do **YOU** think is the cause of your pain?

_____

_____

_____

EFFECTS OF PAIN:

Circle the number to indicate how much your pain has interfered with your activities this **past week.**

0	1	2	3	4	5	6	7	8	9	10

No Interference — Mild Interference — Moderate Interference — Severe Interference — Complete Interference

Previous Doctors

List ALL of the doctors you have seen for your pain problem

Date	Name	Specialty	Address / Phone / Fax

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PREVIOUS MEDICATIONS: List all previous medications you have taken for pain:

Name of Medicine	Dose	Dates of Use	Helpful	Reason for stopping
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	

PREVIOUS TREATMENTS:

Indicate which of the following treatments you have tried for your pain problem:

❑ Nerve Blocks ❑ Chiropractor ❑ Psychotherapy ❑ Relaxation Training

❑ Acupuncture ❑ Physical Therapy ❑ Biofeedback ❑ Exercise Program

❑ Other (list): _____

DIAGNOSTIC TESTS:

Please list, in chronological order, all tests and x-rays performed to evaluate your pain:

Date	Test	Results

PAST MEDICAL PROBLEMS, SURGERIES, HOSPITALIZATIONS OR INJURIES:

Year	Describe	Hospital	Doctor

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ALLERGIES: ❑ No Known Allergies

Medicine	Reaction	Medicine	Reaction

REVIEW OF SYSTEMS:

Please check if you <u>have</u> **or** <u>had</u> any of the following:

General
❑ Weight loss
❑ Poor appetite
❑ Severe fatigue / low energy
❑ Cancer

Hematological
❑ Anemia
❑ Easy bruising
❑ Bleeding disorder
❑ Taking blood thinners
❑ Blood Transfusion:
❑ Yes ❑ No
Reaction:_____

Skin
❑ Rash
❑ Nail changes
❑ Bumps / nodules

Head and Neck
❑ Headaches
❑ Visual changes
❑ Mouth problems
❑ Neck pain
❑ TMJ problems

Cardiac
❑ Exercise limitations
❑ Chest pain
❑ Irregular heartbeat
❑ Heart murmurs
❑ High or low blood pressure
❑ Circulation problems
❑ Ankle swelling

Pulmonary
❑ Shortness of breath
❑ Cough
❑ Asthma or bronchitis
❑ Lung disease
❑ Sleep apnea
❑ Snoring

Endocrine
❑ Diabetes
❑ Thyroid problems

Gastrointestinal
❑ Abdominal Pain
❑ Nausea or vomiting
❑ Constipation
❑ Diarrhea
❑ History of ulcers or heartburn

Genitourinary
❑ Frequent or hesitant urination
❑ Pain with urination
❑ Blood in urine
❑ Incontinence
❑ Sexual dysfunction

Musculoskeletal
❑ Arthritis -Type:_____
❑ Osteoporosis
❑ Muscle pain
❑ Muscle wasting
❑ Fractures

Neurologic
❑ Numbness
❑ Weakness
❑ Falling
❑ Stroke
❑ Seizures
❑ Memory Loss
❑ Loss of balance

Infectious Diseases
(check all that apply)
❑ Measles ❑ Mumps
❑ Chicken Pox
❑ Rheumatic fever
❑ Hepatitis A
❑ Hepatitis B
❑ Hepatitis C
❑ Other:_____
❑ HIV ❑ AIDS
❑ Herpes (Oral)
❑ Herpes (Genital)
❑ Shingles
❑ Post-herpatic neuralgia

<u>In the last 5 years:</u>
Received:
Pneumovax: ❑ Yes ❑ No
Flu shot: ❑ Yes ❑ No

Gynecologic
❑ Pregnant
❑ Post-menopausal:
Last Menstrual Period:_____

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HABITS:

Smoking: ❑ Yes ❑ No ❑ Quit Packs per day: _____ Number of years smoked: _____

Alcohol use: ❑ None ❑ Occasional ❑ Daily How much per week? _____

Are you currently using recreational drugs? ❑ No ❑ Yes: ❑ Amphetamines ❑ Cocaine ❑ Heroin ❑ Marijuana ❑ Other: _____

Do you drink caffeine (coffee, tea, etc.)? How many cups per day? _____

Do you clench your teeth? ❑ Yes ❑ No

Do you grind your teeth? ❑ Yes ❑ No

Do you wear a night guard over your teeth? ❑ Yes ❑ No

EXERCISE:

Do you exercise? ❑ No ❑ Yes, what type? _____

How many days per week do you exercise? _____

How long do you exercise each time (on average)? _____

FAMILY HISTORY: Are you adopted? ❑ Yes ❑ No

Member	Deceased or Living		Age	Medical Problems
Father	❑	❑		
Mother	❑	❑		
Siblings	❑	❑		
	❑	❑		
	❑	❑		
	❑	❑		
Spouse	❑	❑		

SOCIAL HISTORY:

Relationship Status: ❑ Single ❑ Separated ❑ Married ❑ Widowed ❑ Domestic Partner: ❑ Female ❑ Male

With whom do you live? Name: _____ Relationship: _____

Highest level of education completed: ❑ Less than High School ❑ High School ❑ Vocational ❑ Graduate ❑ College ❑ Other: _____

Current or most recent occupation: _____

Status: ❑ Full Time ❑ Part time ❑ Self-employed ❑ Homemaker ❑ Retired ____ years ❑ Unemployed _____ years due to pain ❑ Unemployed ____ years due to _____

Are you happy with your job? ❑ Yes ❑ No

Are you on Disability? ❑ No ❑ Yes, Date Started: _____

Reason for disability: _____

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PSYCHOLOGICAL HISTORY:

Describe your mood: _____

_____

Do you have problems with any of the following:

❑ Concentration ❑ Motivation ❑ Sleep ❑ Appetite ❑ Anxiety
❑ Depression ❑ Self-worth ❑ Homicidal thoughts ❑ Suicidal thoughts

Do you have a history of physical or mental abuse? ❑ Yes ❑ No

Are you currently in therapy? ❑ No ❑ Yes, who do you see? _____ Phone # _____

FINANCIAL INFORMATION:

Do you have any legal action pending related to this pain or any other health problem?

❑ No ❑ Yes, Attorney's name: _____ Phone # _____

Address: _____

HEALTHCARE DECISIONS: *(Check boxes that apply)*

❑ Patient prefers to make own medical decisions.
❑ Medical decisions are made jointly between patient and family.
❑ Patient prefers family members to make the major medical decisions.
❑ Patient has Advance Directives: ❑ Yes* ❑ No
* If Yes, Copy of Directives given to CSMC: ❑ Yes ❑ No

Source of information if other than patient: _____

Signature of person acquiring this information: _____

Signature of patient: _____ Date: _____

Evaluation reviewed by Physician:

_____	_____	_____	_____
Name of Physician (*please print*)	Signature of Physician	ID#	Date Signed

For Clinical Use Only:

Blood Pressure: _____ / _____ Heart Rate: _____ Respiration Rate: _____