## JAMES D. ELLNER, M.D. GEORGIA PAIN MANAGEMENT

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## PAIN HISTORY AND INFORMATION

Please read the sheets carefully and answer all the questions to the best of your ability. This information will assist us in better treating your pain. Thank you for your time and corporation.

NAME:					C	DATE OF BIRTH:			
	LAST		FIRST		M. I.				
Height:				Weight:					
REFFERING I	PHYSICIAN(S):								
Who is your	Primary Care Phys	sician?							
**Please sha	ade in the areas or	n the diagram v	vhere your pain is	located.					
1. What inc	reases your pain?								
<b>2.</b> What ded	creases your pain?								
3. Please CI	RCLE the appropri	ate words that	best describe you	ır pain:					
Aching Heavy Stabbing	Burning Hot Stiff		Constant Intermittent Throbbing		Dull Sharp Tingling	Electrical Shooting Weak	Excruciating Sore		
<b>4.</b> Does this	problem cause yo	ou to have diffic	culty with (circle a	II that apply):					
Completing	household chores	Com	pleting tasks at w	ork Drivi	ng a Car Exe	rcise Slo	eeping		
5. On a scal	e of <b>1-10</b> with 10 r	meaning the wo	orst pain and 0 me	eaning no pain,					
How high ca	n your pain level g	go up to?:		How low can	your pain leve	go down to?:			

DATE		LOCATION	
ON			
e done, when was it	done, and by which p	bhysician?	
Participated?	Pain Relief	Approximate Date	Still participating?
Yes No	Yes No Some	what	Yes No
Yes No	Yes No Some	what	Yes No
Yes No	Yes No Some	what	Yes No
Yes No	Yes No Some	what	Yes No
Yes No	Yes No Some	what	Yes No
Yes No	Yes No Some	what	Yes No
Yes No	Yes No Some	what	Yes No
Yes No	Yes No Some	what	Yes No
	Yes No Some	what	Yes No
	n any of the followin  Participated?  Yes No  The followin  Yes No  The followin  The	ions, procedures, or surgeries in the past e done, when was it done, and by which participated?  Participated?  Yes No Yes No Some Yes No Some Yes No Yes No Yes No Some Yes No Yes No Some Yes No Some Yes No Some Yes No Yes No Some Yes No Yes No Some Yes No Some Yes No Some Yes No Yes No Some Yes No Yes	ions, procedures, or surgeries in the past year FOR THIS PROBLEM? YE e done, when was it done, and by which physician?  In any of the following treatments FOR THIS PROBLEM in the last two year  Participated? Pain Relief Approximate Date  Yes No Yes No Somewhat  Yes No Somewhat  Yes No Yes No Somewhat  Yes No Somewhat

\*\*Please indicate which diagnostic procedures/test you have had and the approximate date and location where the test

## **MEDICAL HISTORY**

Do you currently hav circle <u>)</u>	ve, have	had in the pas	st, or are to	king medi	cation fo	r the fo	llowing	g condit	tions? (please
CARDIOVASCULAR:	A-fib	Anemia	Aneurysm	Blood	Clot	Cellulit	is	Chest p	oain
Congestive Heart Failu	re	Heart Attack	Heart Dis	ease He	art murn	nur	High bl	ood pre	ssure
High cholesterol	Irregula	ar heart beat	Mitral Val	e Prolapse	Stroke	e TIA	(mini s	troke)	
ENDOCRINE:									
Diabetes Type 1	Diabete	es Type 2	Goiter	Hyperthyroi	dism	Hypotl	nyroidisr	m	Pancreatitis
GASTRO INTESTIN	IAL:	Acid Reflux (GE	ERD) Cir	rhosis	Constip	ation	Crohn's	5	Diarrhea
Diverticulitis Gallsto	ones	Hemorrhoids	Hepatitis (	which one?_	)	Hernia		Irritabl	e Bowel
Liver Problems	Ulcer								
RESPIRATORY:	Chronic	Bronchitis	COPD Sh	ortness of E	Breath	Season	al Allerg	ies	Sleep Apnea
GENTOURINARY/RE	PRODUC	CTIVE:							
Benign Prostatic Hyper	trophy (I	BPH) Endom	netriosis E	rectile dysfu	nction	Kidney	/Renal o	disease	Kidney Stone
Low testosterone	Painful	periods	Polycystic	ovaries	Urinary	Inconti	nence	Urinary	/ Tract Infectio
MUSCULOSKELATAL	<u>.:</u>								
Bursitis Degen	erative D	isc Disease	Degenerat	ive Joint Dis	ease	Fibrom	yalgia	Gout	Kyphosis
Osteoarthritis Oste	omyelitis	Osteopenia	Osteopo	rosis Rhe	umatoid	Arthritis	s Sc	oliosis	
PSYCHOLOGICAL/N	EUROLO	GICAL							
ADD or ADHD Addic	tion	Alcoholism	Alzheimer	s Disease	Anxiety	/Panic A	Attacks	Bell's P	alsy Bipol
Brain Injury Deme	ntia	Depression	Dizziness	Heada	ches	Hearing	g Loss	Insomr	nia
Memory Issues	Migrair	nes Parkins	son's Diseas	e PTSD	Restles	s Leg Sy	ndrome	Sch	izophrenia
Seizures/Epilepsy	Shingle	s hx. of S	Spinal Menir	ngitis	Substa	nce Abu	se	Vertigo	)
Suicidal Thoughts	Vision I	Problems (catara	acts, legally	blind)					
OTHER: hx. of MRS.	A HIV/	'AIDS Lyme's	disease	Malignant H	Hyperthei	rmia	Bleeding	g disord	er
List any conditions you	have tha	at are not menti	oned above						
			FAMIL	HISTORY					

## **SURGICAL HISTORY**

Surgery			Date	Surgery			Date
		SOC	CIAL HIS	TORY			
1. Do you currently use tob	acco products?	ı	YES	NO	NEVE	R HAVE USED	•
If yes, what products?	Cigarettes	Chew/S	Snuff/Di	p Cigar	Pipe		
How long have you	be using tobaco	co?					
**If no, how long has it bee							
2. Do you currently use alc			YES	NO		R HAVE USED	
**If yes, how often do you	drink?						
3. Do you currently use illic	cit or illegal drug	gs? (Examples	s: marijı	uana/cocaine/meth/e	cstasy/he	roin)	
			YES	NO	NEVE	R HAVE USED	•
**If yes, which drugs do yo	u use?						
4. Do you currently exercis	e?		YES	NO	NEVE	R HAVE	
**If yes, what type of exerc	rises do you do a	and how ofte	n do yo	u do them?			
If no, were you exercising u					NO		
5. Do you have a support s		-	-			NO	
	-		EDICATI				
Please list <u>ALL</u> medications	you take, inclu	ding over-the	-counte	r meds, vitamins, and	d prescript	ions from oth	er doctors.
Medication name		How Often		Medication name			How Ofte
		•				. 37	•
Please add any addition cor	mments you wis	sh to make he	ere.				
•	,						
							_
Patient signature					Tada	y's Date	