ATLANTIC PAIN MANAGEMENT & REHABILITATION, P.C.

Please complete the following form. We will use this information to update your file. Thank you.

NAME_____ **DOB:** _____ **DATE:** _____

Do you currently smoke or use smokeless tobacco? ☐ Yes ☐ No If yes, how much?_____

Do you currently drink alcohol? ☐ Yes ☐ No If yes, how much?_____

If no to any of the above, have you ever smoked cigarettes, used smokeless tobacco, or consumed alcohol? ☐ Yes ☐ No

If yes, please describe:_____

Do you currently use recreational drugs? ☐ Yes ☐ No

If yes, what type and how much? _____

Have you had abuse problems with recreational drugs in the past? ☐ Yes ☐ No

If yes, please describe:_____

Have you had abuse problems with prescription medications in the past? ☐ Yes ☐ No

If yes, please describe:_____

Are there any recreational drug problems, or problems with prescription medications in your household at the present time?

☐ Yes ☐ No If yes, please describe:_____

Please check the appropriate diseases with regards to your family history:

	High Blood Pressure	Diabetes	Heart Disease	Cancer	Arthritis	Stroke
Mother	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐
Sons	☐	☐	☐	☐	☐	☐
Daughters	☐	☐	☐	☐	☐	☐
Aunts/Uncles	☐	☐	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐	☐	☐

Please check any problem(s) that you may have from the list below:

Abdomen
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody Stools
- ☐ Heartburn

Ear/Nose/Throat
- ☐ Ringing in Ears
- ☐ Loss of Hearing
- ☐ Nose Bleeds
- ☐ Sore Throat
- ☐ Hoarseness

Genitourinary
- ☐ Pain with Urination
- ☐ Inability to Urinate
- ☐ Incontinence
- ☐ Bloody Urination
- ☐ Decreased Desire for Sex

Neurological
- ☐ Fainting Spells
- ☐ Weakness
- ☐ Dizziness
- ☐ Headaches
- ☐ Tremors

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Memory Loss
- ☐ Suicidal Ideation
- ☐ Inability to Sleep

Endocrine
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Excessive Thirst
- ☐ Cold Intolerance
- ☐ Heat Intolerance

General
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Sweats

Eyes
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Irritation
- ☐ Discharge

Lungs
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Cough Up Blood
- ☐ Sleep Apnea

Skin
- ☐ Rashes
- ☐ Coldness of Hands/Feet
- ☐ Dry Skin
- ☐ Easy Bruising

Heart
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Heart Murmur

Musculoskeletal
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Cramps