MARTIN J. LOPEZ, M.D.
INTERVENTIONAL PAIN MANAGEMENT

Pain Management Questionnaire

Today's Date _____

Name _____ Date of Birth _____ Age _____

Height _____ Weight _____ Social Security # _____

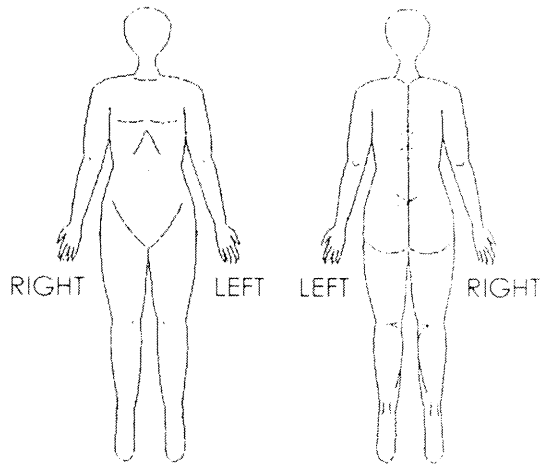
Referring Doctor _____ Primary Care Doctor _____

Date of Injury _____ Date Pain Began _____

Describe Event/Onset _____ Cell _____

_____

On the diagram to the right, shade in the area(s) where your pain is located.



Using a scale from 0 (no pain) through 10 (excruciating), rate your pain... (circle response):

At its WORST	0	1	2	3	4	5	6	7	8	9	10
At its LEAST	0	1	2	3	4	5	6	7	8	9	10
At its USUAL	0	1	2	3	4	5	6	7	8	9	10
TODAY	0	1	2	3	4	5	6	7	8	9	10

	Do you have? (check all that apply & list where)		Check any form of treatment you've received for pain
	Burning		Previous Injections/Blocks (describe specific treatments & doctor performing them below)
	Aching		
	Throbbing		
	Sharp		
	Dull		
	Shooting		Physical Therapy / When?
	Stabbing		Chiropractors/Manipulation
	Numbness		Acupuncture
	Increased Swelling		TENS Unit
	Weakness		Psychotherapy/Psychiatric Therapy
	Tingling, Pins/Needles		Check any test performed for evaluation of pain (indicate where & when test was performed)
	Coldness		
	Skin Discoloration		Lumbar MRI
	Muscle Spasm		
	Muscle Tightness		Cervical MRI
	Bowel or Bladder Problems (please describe below)		CAT Scan
	Other (please describe below)		Myelogram
			X-Rays
			Bone Scan
			EMG
			Discogram
			Other

Have you been hospitalized or had surgery for your pain? _____Yes _____No

If yes, list the following:

Hospital _____ Doctor _____ Date _____

Explain _____

What time of day is your pain at its worst? _____Morning _____Afternoon _____Evening _____Night

On average, how many hours per night do you sleep? _____

Has your appetite changed since the onset of pain? _____Increased _____Decreased _____No Change

If you have both back & let pain, what is percent is... _____% Back? _____% Leg?

How do the following affect your pain?							
	Makes Better	Makes Worse	Neither		Makes Better	Makes Worse	Neither
Relaxation				Standing			
Heat				Walking			
Cold				Lying Down			
Alcoholic Drinks				Exercise			
Oral Medications				Sexual Activity			
Sitting				Coughing, Sneezing			

PAST MEDICAL HISTORY

Have you had.../Do you currently have ...? (check all that apply)					
	Arthritis (type)		Anticoagulant/Blood Thinners		Heart Murmur
	Glaucoma/Cataracts		Lung Disease		Hepatitis
	Abnormal X-Ray/CT/MRI		(COPD/Emphysema)		Mononucleosis
	Back Trouble		Jaundice		Fracture of Neck or Back
	Blood Disease		Paralysis		Kidney Disease
	Stroke		Thyroid Disease		Diabetes
	Positive HIV/AIS test		Psychiatric or Mental Disorder		Blood Transfusion
	Abnormal EKG (electrocardiogram)		Depression		Fracture of Facial Bones
	Abnormal Bleeding Tendencies		Anxiety		GI/Stomach Disorder
	Cancer (list type below)		Abnormal Muscle Weakness		High Blood Pressure
			Muscular Disorder		High Cholesterol/Triglyceride
	Asthma		Bone Disease		Any Type of Infection
	Epilepsy or Seizures		Heart Attach		(please describe)

PAST SURGICAL HISTORY

List previous surgeries and dates _____

_____

_____

List any hospitalizations in previous 12 months _____

_____

_____

List all PAIN MEDICATIONS you are currently taking, including dose & frequency _____

_____

_____

_____

List all OTHER MEDICATIONS you are currently taking (prescription and over-the-counter) _____

_____

Have you taken any blood thinners such as Coumadin (Warfarin) or Heparin _____Yes _____No
If yes, when?

_____

List any KNOWN ALLERGIES TO MEDICATIONS _____

_____

What, if any, medical problems run in your family? _____

_____

SOCIAL HISTORY

Do you...? (check all that apply)	
	Object to Blood Transfusion
	Drink Alcohol (circle one: accasionally / frequently / daily)
	Use Street Drugs or Have a History of Substance Addiction/Abuse
	Use Tobacco (____ packs per day)
	Are you Pregnant?
	Number of Children
	Marital Status, please circle one: Married Single Divorced Widowed

Level of Education _____

Occupation _____

Are you working? _____Yes _____No If no, last day worked _____

Is this a Workers' Comp injury? _____Yes _____No If yes, list any previous Workers' Comp injuries

_____

_____

R.O.S.

Do you currently have...? **(check all that apply)**					
	Fever		Wheezing		Excessive Skin Dryness
	Unexpected Weight Loss		Coughing		Muscle Aches
	Fatigue		Heartburn/Reflux		Joint Pain/Swelling
	Hearing Loss		Abdominal Pain		Numbness
	Sinus Problems		Diarrhea/Constipation		Weakness
	Sore Throat		Vomiting		Headaches
	Chest Pain		Urinary Pain/Discomfort		Paralysis
	Irregular Heartbeat		Blood in Urine		Other (describe below)
	Shortness of Breath		Skin Rashes		

Martin J. Lopez, M.D.

Pain Management
Board Certified/Fellowship Trained
Anesthesiology
Board Certified

PATIENT INFORMATION
(PLEASE PRINT)

NAME _____ DATE _____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ BUSINESS PHONE _____ SOCIAL SEC. NO. _____

DATE OF BIRTH _____ AGE _____ SEX M F _____ MARITAL STATUS S M W D SEP. _____

REFERRED BY _____ PERSONAL PHYSICIAN _____

PATIENT'S EMPLOYER _____ POSITION _____

BUSINESS ADDRESS _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____

PERSON RESPONSIBLE FOR BILL
(IF OTHER THAN ABOVE)

NAME _____ RELATIONSHIP _____

ADDRESS (IF OTHER THAN ABOVE) _____ HOME PHONE _____

EMPLOYER _____ POSITION _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

INSURANCE, MEDICARE, WORKER'S COMPENSATION OR WELFARE INFORMATION

NAME OF POLICY HOLDER _____

MEDICARE NO. _____ MEDICAID NO. _____

FIRST INSURANCE COMPANY OR PROGRAM _____ GROUP NUMBER _____ POLICY NUMBER _____

ADDRESS (MAKE COPY OF INSURANCE CARD _____ TELEPHONE _____

SECOND INSURANCE COMPANY OR PROGRAM _____ GROUP NUMBER _____ POLICY NUMBER _____

ADDRESS (MAKE COPY OF INSURANCE CARD _____ TELEPHONE _____

NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY

NAME _____ RELATIONSHIP _____

ADDRESS _____ HOME PHONE _____

EMPLOYER _____ POSITION _____ BUSINESS PHONE _____

REFERRAL SOURCE

REFERRED BY (CIRCLE ONE): PHYSICIAN NAME _____; FRIEND; FAMILY; ACQUAINTED WITH DOCTOR; WITH STAFF; YELLOW PAGES; HEALTH PLAN; REFERRAL SERVICE; OTHER _____

ALLERGIES: _____

AUTHORIZATIONS

FINANCIAL RESPONSIBILITY AND BENEFITS TO PHYSICIAN:

I understand that I am financially responsible for services rendered by the physician and his/her staff, unless a contract exists between the physician and my insurance company that supercedes my financial obligation or in the case of authorized Worker's Compensation. I authorize my insurance company to pay benefits directly to the physician.

Date _____ Signature (Insured Person) _____

RELEASE OF INFORMATION:

I hereby authorize release of all information from Martin J. Lopez, M.D., PC. Martin J. Lopez, M.D., PC may disclose any or all of the patient's information for insurance claim purposes. If some other party is paying the patient's bill or by any contract may be expected to pay the bill, then Martin J. Lopez, M.D., PC may disclose any or all of the patient's information to that party to verify charges. Martin J. Lopez, M.D., PC may disclose any or all of the patient's information to the patient's attending physician, consulting physician(s) and other health care providers who have a legitimate need for such information in the care and treatment of the patient. **THE INFORMATION RELEASED MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).**

I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations.

Date _____ Signature (Insured Person) _____

Photostat of the above is as valid as the original.

Notice of Privacy Practices and Disclosure

In accordance with Federal regulations, your health information may be used as necessary by staff member or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. Your information may also be used to seek payment from your health plan, or from other sources of coverage.

Additional Disclosure Authorization

I, _____ authorize the disclosure of my health information to the individual(s) listed below:

Name of person / relationship

_____

Name of person / relationship

_____

This authorization is effective through ____/_____/_____ unless revoked or terminated earlier by the patient or the patient's personal representative. You may revoke or terminate this authorization by submitting a written request to our office.

Disclosure Restrictions

Are there any restrictions to the release of medical information? If yes, please explain:_____

_____

_____

_____

Patient's Name (print):_____Date of Birth:_____

Patient's Signature:_____Date:_____

Signature of Patient's Representative:_____

Relationship to Patient:_____