

Hawai'i Pain Center

2226 Liliha Street, Suite 407, Honolulu, HI 96817

☎ 808-445-9172 📠 808-445-9182

Patient: _____ Date-of-Birth _____

Past Medical History — check all that apply

<p>Head</p> <input type="checkbox"/> Trauma	<p>Respiratory</p> <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> COPD – Bronchitis/Emphysema <input type="checkbox"/> Pleuritis <input type="checkbox"/> Pneumonia	<p>Musculoskeletal</p> <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Musculoskeletal injury	<p>Endocrine</p> <input type="checkbox"/> Goiter <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Thyroiditis <input type="checkbox"/> Diabetes, type 1 <input type="checkbox"/> Diabetes, type 2
<p>Eyes</p> <input type="checkbox"/> Blindness <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Wear glasses/contacts	<p>Gastrointestinal</p> <input type="checkbox"/> Cirrhosis <input type="checkbox"/> GERD <input type="checkbox"/> Gallbladder disease <input type="checkbox"/> Heartburn <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Jaundice <input type="checkbox"/> Ulcer	<p>Skin</p> <input type="checkbox"/> Dermatitis <input type="checkbox"/> Mole(s) <input type="checkbox"/> Other skin condition(s) <input type="checkbox"/> Psoriasis	<p>Heme/Onc</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Cancer
<p>Ears</p> <input type="checkbox"/> Hearing aids	<p>Genitourinary</p> <input type="checkbox"/> Hernia <input type="checkbox"/> Incontinence <input type="checkbox"/> Nephrolithiasis <input type="checkbox"/> Other kidney disease <input type="checkbox"/> Sexually transmitted disease (STD) <input type="checkbox"/> Urinary tract infection (UTI)	<p>Neurological</p> <input type="checkbox"/> Epilepsy <input type="checkbox"/> Seizures <input type="checkbox"/> Severe headaches, migraines <input type="checkbox"/> Stroke <input type="checkbox"/> TIA	<p>Infectious</p> <input type="checkbox"/> HIV <input type="checkbox"/> STDs (sexually transmitted disease) <input type="checkbox"/> Tuberculosis (disease) <input type="checkbox"/> Tuberculosis (exposure)
<p>Nose/Sinuses</p> <input type="checkbox"/> Allergic rhinitis <input type="checkbox"/> Sinus infections		<p>Psychiatric</p> <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Depression <input type="checkbox"/> Hallucinations, delusions <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Suicide attempts	<p>Other Not Listed:</p> <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
<p>Mouth/Throat/Teeth</p> <input type="checkbox"/> Dentures			
<p>Cardiovascular</p> <input type="checkbox"/> Aneurysm <input type="checkbox"/> Angina [chest pain] <input type="checkbox"/> Deep venous thrombosis (DVT) <input type="checkbox"/> Dysrhythmia <input type="checkbox"/> Hypertension (HTN) <input type="checkbox"/> Murmur <input type="checkbox"/> Myocardial infarction (heart attack) <input type="checkbox"/> Other heart disease			

Past Surgical History — check all that apply

<input type="checkbox"/> Aneurysm repair <input type="checkbox"/> Appendectomy <input type="checkbox"/> Back Surgery <input type="checkbox"/> Bariatric surgery/gastric bypass <input type="checkbox"/> Bilateral tubal ligation <input type="checkbox"/> Breast resection or mastectomy <input type="checkbox"/> Coronary artery bypass graft (CABG) <input type="checkbox"/> Carotid endarterectomy or stent <input type="checkbox"/> Carpal tunnel release surgery	<input type="checkbox"/> Cataract/lens surgery <input type="checkbox"/> Cesarean section <input type="checkbox"/> Cholecystectomy/bile duct surgery <input type="checkbox"/> Dilatation & curettage (D&C) <input type="checkbox"/> Hemorrhoid surgery <input type="checkbox"/> Hip arthroplasty <input type="checkbox"/> Hip replacement <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Inguinal hernia repair	<input type="checkbox"/> Knee arthroplasty (replacement) <input type="checkbox"/> LASIK <input type="checkbox"/> Laminectomy <input type="checkbox"/> Nasal surgery <input type="checkbox"/> PTCA/PCI <input type="checkbox"/> Pacemaker/defibrillator <input type="checkbox"/> Prostate surgery <input type="checkbox"/> Prostatectomy <input type="checkbox"/> Rotator cuff surgery	<input type="checkbox"/> Sinus surgery <input type="checkbox"/> Skin cancer excision <input type="checkbox"/> Spinal fusion <input type="checkbox"/> TAH-BSO, total abdominal hysterectomy bilateral salpingo oophorectomy <input type="checkbox"/> TURP – transurethral resection of the prostate <input type="checkbox"/> Tonsillectomy or adenoidectomy <input type="checkbox"/> Vasectomy
			<p>Other Not Listed:</p> <input type="checkbox"/> _____ <input type="checkbox"/> _____

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Family History Family history unknown

Mother: Alive Deceased Unknown

<input type="checkbox"/> No Health Problem <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Coronary artery disease (< age 55) <input type="checkbox"/> COPD <input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> Hypertension <input type="checkbox"/> Mental illness <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke	<input type="checkbox"/> Breast cancer <input type="checkbox"/> Colon cancer <input type="checkbox"/> Other cancer: _____ <input type="checkbox"/> Ovarian cancer <input type="checkbox"/> Uterine cancer
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Father: Alive Deceased Unknown

<input type="checkbox"/> No Health Problem <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Coronary artery disease (< age 55) <input type="checkbox"/> COPD <input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> Hypertension <input type="checkbox"/> Mental illness <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke	<input type="checkbox"/> Breast cancer <input type="checkbox"/> Colon cancer <input type="checkbox"/> Other cancer: _____ <input type="checkbox"/> Prostate cancer
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Social History — check all that apply

Tobacco <input type="checkbox"/> Current every day smoker <input type="checkbox"/> Current some day smoker <input type="checkbox"/> Former smoker <input type="checkbox"/> Heavy tobacco smoker <input type="checkbox"/> Light tobacco smoker <input type="checkbox"/> Never smoker	Alcohol <input type="checkbox"/> Do not drink <input type="checkbox"/> Drink daily <input type="checkbox"/> Frequently drink <input type="checkbox"/> History of alcoholism <input type="checkbox"/> Occasional drink Drug Abuse <input type="checkbox"/> Intravenous drug use <input type="checkbox"/> Illicit drug use <input type="checkbox"/> No illicit drug use	Other <input type="checkbox"/> Cannabis/Marijuana user <input type="checkbox"/> Cigar smoker <input type="checkbox"/> Chew tobacco <input type="checkbox"/> Electronic Cigarette/Vapor user
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Review of Systems — check all that apply

Constitutional	<input type="checkbox"/> fever <input type="checkbox"/> night sweats <input type="checkbox"/> chills <input type="checkbox"/> cold intolerance <input type="checkbox"/> fatigue <input type="checkbox"/> daytime sleepiness <input type="checkbox"/> weight gain <input type="checkbox"/> weight loss <input type="checkbox"/> increased thirst <input type="checkbox"/> increased hunger/over eating <input type="checkbox"/> anorexia
Eyes	<input type="checkbox"/> change in vision <input type="checkbox"/> loss of vision <input type="checkbox"/> blurred vision <input type="checkbox"/> double vision <input type="checkbox"/> eye redness <input type="checkbox"/> eye pain <input type="checkbox"/> tearing <input type="checkbox"/> pus discharge
Ears	<input type="checkbox"/> difficulty hearing <input type="checkbox"/> hearing loss <input type="checkbox"/> ear pain/ear ache <input type="checkbox"/> ear drainage <input type="checkbox"/> tinnitus
Nose	<input type="checkbox"/> nasal congestion <input type="checkbox"/> nasal discharge <input type="checkbox"/> nose bleeding <input type="checkbox"/> sneezing <input type="checkbox"/> snoring
Mouth/Throat/Voice	<input type="checkbox"/> lip sores <input type="checkbox"/> mouth sores <input type="checkbox"/> tongue sores <input type="checkbox"/> sore throat <input type="checkbox"/> difficulty swallowing <input type="checkbox"/> painful swallowing <input type="checkbox"/> gum bleeding <input type="checkbox"/> dental problems <input type="checkbox"/> hoarse voice <input type="checkbox"/> change in voice quality
Neck	<input type="checkbox"/> neck pain <input type="checkbox"/> neck stiffness <input type="checkbox"/> neck lumps <input type="checkbox"/> neck swelling
Respiratory	<input type="checkbox"/> difficulty or labored breathing <input type="checkbox"/> cough <input type="checkbox"/> cough productive of sputum <input type="checkbox"/> coughing up blood <input type="checkbox"/> wheezing
Cardiovascular	<input type="checkbox"/> chest pain <input type="checkbox"/> rapid heart rate <input type="checkbox"/> shortness of breath at rest <input type="checkbox"/> shortness of breath with activity <input type="checkbox"/> shortness of breath when lying flat <input type="checkbox"/> shortness of breath at night <input type="checkbox"/> leg/feet swelling <input type="checkbox"/> varicose veins
Breast	<input type="checkbox"/> breast lump (past or present) <input type="checkbox"/> breast pain <input type="checkbox"/> nipple discharge

Review of Systems, cont. — check all that apply

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Pain Medication History — check all that apply

NSAIDs/Anti-inflammatories	Improvement	Side Effects/Type?
Tylenol, acetaminophen, APAP	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Percogesic (acetaminophen + phenyltoloxamine)	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Percogesic (Mg salicylate)	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Aspirin (acetylsalicylic acid)	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Motrin, Advil, ibuprofen	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Duexis (ibuprofen + famotidine)	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Naprosyn, Aleve, naproxen, naprelan 500	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Vimovo (naproxen + esomeprazole)	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Relafen, nabumetone	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Mobic, meloxicam	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Feldene, piroxicam	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Clinoril, sulindac	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Disalcid, salsalate	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Voltaren, diclofenac	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Arthrotec (diclofenac + misoprostol)	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Lodine, Etodolac	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Toradol, ketorolac	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Indocin, indomethacin	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Daypro, oxaprozin	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Celebrex, celecoxib	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Muscle Relaxers		
Flexeril, cyclobenzaprine	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Robaxin, methocarbamol	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Baclofen, lioresal	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Zanaflex, tizanidine	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Skelaxin, metaxalone	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Dantrium, dantrolene	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Norflex, orphenadrine	<input type="checkbox"/> Yes <input type="checkbox"/> no	
SOMA, carisoprodol	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Paraflex, chlorzoxazone	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Parafon Forte (chlorzoxazone + acetaminophen)	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Valium, diazepam	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Nerve Stabilizers		
Neurontin, gabapentin	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Lyrica, pregabalin	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Topamax, topiramate	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Mexitil, mexiletine	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Tegretol, carbamazepine	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Trileptal, oxcarbazepine	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Lamictal, lamotrigine	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Analgesic Anti-Depressants		
Elavil, amitriptyline	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Pamelor, nortriptyline	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Norpramin, desipramine	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Tofranil, imipramine	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Effexor, venlafaxine	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Cymbalta, duloxetine	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Savella, milnacipran	<input type="checkbox"/> Yes <input type="checkbox"/> no	

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Pain Medication History — check all that apply

Topicals	Improvement	Side Effects/Type?
Salonpas patches	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Thermacare patches	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Penetrex cream	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Capzasin, capsaicin cream	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Biofreeze, Sports cream (menthol + camphor)	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Voltaren gel	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Lidocaine-Prilocaine cream	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Flector patch/diclofenac	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Lidoderm, lidocaine patches	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Compound cream	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Short-Acting Opioids		
Short-Acting Opioids	Improvement	Side Effects/Type?
Ultram, tramadol	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Ultracet (tramadol + APAP)	<input type="checkbox"/> Yes <input type="checkbox"/> no	
T3, T4 (codeine + APAP)	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Talwin, pentazocine	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Talwin NX (pentazocine + naloxone)	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Stadol, Butorphanol	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Demerol, meperidine	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Vicodin, Lortab, Norco (hydrocodone + APAP)	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Percocet, Roxicet, Endocet (oxycodone + APAP)	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Roxicodone (oxycodone IR)	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Nucynta, tapentadol	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Dilaudid, hydromorphone	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Morphine IR	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Opana IR, oxymorphone IR	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Long-Acting Opioids		
Long-Acting Opioids	Improvement	Side Effects/Type?
Ultram ER, tramadol ER	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Butrans, buprenorphine patch	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Subutex, buprenorphine	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Suboxone (buprenorphine + naloxone)	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Nucynta ER, tapentadol ER	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Zohydro ER, hydrocodone ER	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Hysingla ER, hydrocodone ER	<input type="checkbox"/> Yes <input type="checkbox"/> no	
MS Contin, Kadian, Avinza, morphine ER	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Oxycontin, oxycodone ER	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Opana ER, oxymorphone ER	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Exalgo ER, hydromorphone ER	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Duragesic, fentanyl patch	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Dolophine, methadone	<input type="checkbox"/> Yes <input type="checkbox"/> no	
Levo-Dromoran, levorphanol	<input type="checkbox"/> Yes <input type="checkbox"/> no	