Metro Anesthesia & Pain Management

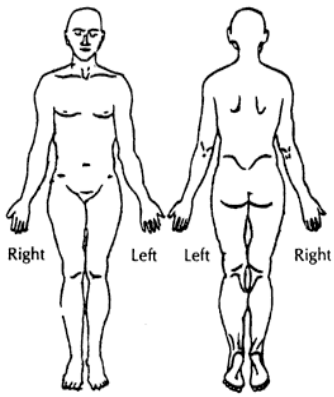
Patient Medical History

NAME_____BIRTH DATE_____AGE _____DATE_____

REFERRING DOCTOR_____FAMILY DOCTOR_____

Where is your pain? _____

Please shade in the affected area



Does your pain radiate to anywhere? _____
_____

When did your pain begin? _____

What caused your pain? (work related, fall, car accident, spontaneous, ect.)
_____

Describe your pain pattern:
constant 75% of the time 50% 25%.

Please rate your pain by circling the one number that best describes your pain at its **WORST** in the last 24 hours:

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the last 24 hours:

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**:

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

Please rate your pain by circling the one number that tells how much pain you have **RIGHT NOW**:

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain as bad as you can imagine

Please use the following scale to choose the one number that describes how, in recent time, pain has interfered with your:

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere Completely Interferes

General Activity_____ Mood_____ Walking Ability_____
Sleep_____ Enjoyment of life_____ Relations with other people_____
Normal Work (includes both work outside the home and housework)_____

Describe your pain: (Circle appropriate response)

burning	throbbing	sharp	dull	shooting	aching	squeezing
stabbing	cramping	penetrating	deep	gnawing		

Aggravating events: (Circle appropriate response)

standing	sitting	lying	walking	sexual activity	bending
eating	heat	cold	coughing	sneezing	twisting
work	stress	other_____			

Please circle all medications that you have tried for this problem:

Anti-inflammatories (Motrin, Aleve, Aspirin, etc.)

Tylenol	Flexeril	Neurontin	Cymbalta	Oxycontin	Morphine	Methadone
Celebrex	Skelaxin	Gralise	Savella	Oxycodone	MsContin	Dilaudid
Voltaren Gel	Zanaflex	Lyrica	Tylenol #3	Percocet	Kadian	Exalgo
Flector Patch	Soma	Topomax	Nubain	Hydrocodone	Avinza	Duragesic/Fentanyl Patch
Pennsaid	Xanax	Tegratol	Demerol	Darvocet	Opana	Butrans Patch
Medrol Dose Pack	Valium Ativan	Amitriptyline Lidoderm Patch	Stadol	Nucynta Ultram/Tramadol	Actiq/Fentora	

Other:_____

Please circle all treatments that you have previously received or are currently receiving for this problem:

Epidural Injection	Physical Therapy	Exercises	Cane or Walker	TENS Unit
Nerve Block/Facet injection	Chiropractor	Relaxation	Brace or Support	
Radiofrequency/Rhizotomy	Acupuncture	Massage	Psychological Treatment	
Trigger Point Injection	Biofeedback	Surgery	Spinal Cord Stimulator/Intrathecal Pump	

Other: _____

What has helped your pain in the past? _____

Previous Testing

X-Ray	MRI	CT Scan	Myelogram	EMG (nerve conduction)
Thermography		Bone Scan	Discogram	Did you bring films today? Yes or No

List all physicians who have treated you for your pain and approximate dates.

_____

_____

Have you been evaluated previously by a pain specialist? Where and when:

_____

_____

Please answer the following questions as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment.

Please use the following scale when answering the following questions:

0=Never, 1=Seldom, 2=Sometimes, 3=Often, 4=Very Often

1. How often do you have mood swings?	0	1	2	3	4
2. How often do you smoke a cigarette within an hour after you wake up?	0	1	2	3	4
3. How often have you taken medication other than the way that it was prescribed?	0	1	2	3	4
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0	1	2	3	4
5. How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4

Past Medical History:

coronary artery disease	heart attack	high blood pressure	emphysema/COPD
hiatal hernia	ulcers	heartburn	asthma
kidney disorder	blood clots	bowel problems	diabetes
liver disorder	hepatitis	HIV	cancer
thyroid disorder	epilepsy	seizures	paralysis
bleeding disorder	stroke	blindness	depression
heart failure	valve problems	glaucoma	anxiety
anemia	arthritis	cataracts	psychiatric disorder
osteoporosis	TB	circulation problems	previous pain

other:_____

Past Surgical History:

Gallbladder	hernia	neck	back
appendectomy	hysterectomy	tonsillectomy	knee
cataract	hip	pacemaker/defibrillator	

other: _____

Medication Allergies: _____

Do you take a blood thinner (Lovenox, Coumadin, Plavix, Aggrenox, Pletal, Effient, Pradaxa, Xarelto, Aspirin…)?

Yes or No

Current Medications:

_____

_____

_____

_____

_____

Who currently prescribes your pain pills? _____

Past Family History: Has any blood relative had any of the following (please circle) and who?
Coronary Artery Disease _____Hypertension _____ Heart Attack _____
Diabetes _____Cancer _____ Stroke _____ Seizures _____
Bleeding Disorders _____ Psychiatric History _____ Alcohol/Substance Abuse _____
Other: _____

Marital status: Married ( ) Single ( ) Divorced ( ) Widowed ( )

List people whom you live with, relationship, and their health

_____

Do you smoke? _____ How much? _____ When did you quit? _____

Do you drink alcohol? (circle) Never socially weekly daily

Do you drink caffeine? _____ How much? _____

Are you currently using any recreational or street drugs? (Circle Yes if used within the past year) Yes or No

Have you ever abused or had an addiction to drugs or alcohol? Yes or No

Have you ever received treatment for drug or alcohol abuse? Yes or No

Current employer: _____ Full-Time _____Part-Time _____Homemaker_____

Complete Review of Systems: Please circle any difficulty or problem you have experienced **within the past month**:

General: Chills, Fever, Night Sweats, Fatigue, Trouble Sleeping, Weight Loss or Gain

Integumentary: New Lesions, Rashes, Itching, Skin Color Changes, Hair and Nail Changes

Head/Eyes/Ears/Nose/Throat: Headache, Visual Disturbances, Vision Loss, Deafness, Decreased Hearing

Respiratory: Shortness of Breath, Cough, Decreased Exercise Tolerance

Cardiac: Chest Pain, Hypertension, Difficulty Breathing Lying Down, Racing Heart, Shortness of Breath, Swelling

Gastrointestinal: Change in Bowel habits, Constipation, Diarrhea, Nausea, Vomiting

Musculoskeletal: Neck Pain, Back Pain, Muscle Spasms, Joint Pain, Muscle Pain

Neurologic: Incontinence Stool, Incontinence Urine, Numbness, Tingling, Weakness

Psychiatric: Anxiety, Depression, Bipolar, Schizophrenia, Suicidal Thoughts, Substance Abuse

Hematologic: Prolonged Bleeding, Spontaneous Bleeding

FOR OFFICE USE ONLY:

Physical Exam

Vitals: BP HR RR WT SOAPP Score

Assessment and Plan

_____

_____

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Dictation conf. #_____

Agreement for Pain Management Services and Medications

Patient Name (print) _____ SS#_____ DOB_____
Address: _____ Phone: _____

- Pharmacy name/address/phone _____

Purpose of this agreement is to prevent misunderstandings about your treatment at Metro Anesthesia and Pain Management. Medications (opioids) can be very useful and helpful in controlling pain. This agreement is essential to the trust and confidence necessary in a provider/patient relationship. To insure safety and comply with regulations, I agree to the following conditions:

1. I will be truthful in reporting my history, current pain symptoms, how the medication is helping control my pain and how pain and the medication affects my life.
2. I will take my meds as prescribed and for the purpose they are prescribed. I will not share/sell/ trade medication.
3. I agree to follow my provider's advice. Controlling pain is a team effort therefore I will be expected to participate in my plan of care. Certain lifestyle changes may be requested and required of me.
4. I will be responsible for my medications by keeping them safe and secure. Stolen medication will be reported to law enforcement. Lost/misplaced/stolen medications may not be replaced.
5. I will not request nor accept controlled substances/opioids from any other physician or individual.
6. I will not use any type of illegal drugs/substances.
7. I will attend office visits on a regular basis and failure to do so will result in a refill denial. I will plan ahead.
8. I agree to random urine/blood drug testing and pill counts at the West or East Des Moines office. These must be completed within 24 hours (at the discretion of the provider) or I am discharged. Refusal to comply will result in discharge from the practice. Due to staffing, you may be required to complete your urinalysis at our East office.
9. Medication refills will be made during regular office hours from 9:00am-4:00pm Mon-Thurs and 9:00am-3:00pm on Friday. No refills on weekends, after hours, or same day. Please call one week ahead to process your request. I am responsible for keeping track of the amount left and allowing the office time to process my request.
10. I agree to use one pharmacy. If I change pharmacies, I will fill out a new agreement with corrected information.
11. I understand the risks of using opioids to include (but not limited to): Constipation, decreased appetite, confusion, problems with coordination or balance (which may make it unsafe to operate dangerous equipment or motor vehicles), drowsiness, low testosterone (males), breathing too slowly or shallow (respiratory depression), physical dependence (withdrawal will occur if I stop the medication abruptly), and/or tolerance (results in needing more medication to achieve the same pain relief). Pregnancy should be reported immediately.
12. If my medication is not controlling my pain, I agree to contact Metro Anesthesia and Pain Management. I will not "self medicate". If pain medications are used excessively, they can cause adverse effects/overdose such as vomiting, constipation, lethargy, organ failure, and even death. I will take my medication only as prescribed.
13. If I overuse my medication, I will run out early and I will be without medications until my refill is due.
14. Medications should never be used in combination with alcohol. This combination could be fatal.
15. I will obtain a yearly physical from my primary care provider including blood work to check liver and kidney function. I will notify this office of any changes/concerns in my health status.
16. If I am discharged from the practice, any family member/associations in this practice may also be discharged.
17. I understand that the *Pain Management Point System* will be enforced as long as I am a patient at Metro Anesthesia and Pain Management. I have received and reviewed the point system.

By signing this agreement, I agree that I have read, understand, and abide by the agreement. I have received a copy of the agreement for future reference. I authorize a copy of this agreement to be released to my pharmacy.

_____ _____
Signature of patient Date

_____ _____
Witness Date

METRO ANESTHESIA & PAIN MANAGEMENT

Consent to Use and Disclosure of Protected Health Information for Treatment, Payment and Health Care Operations

I consent to allow Metro Anesthesia to use or disclose my protected health information for treatment, payment and healthcare operations.

- Treatment means the provision, coordination, or management of health care and related services by one or more health care providers.
- Payment means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care.
- Health Care Operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting; premium rating; and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of Metro Anesthesia.

I have been informed of and given the right to review and secure a copy of Metro Anesthesia & Pain Management's Notice of Privacy Practices prior to signing this Consent. Such Notice of Privacy Practices contains a more complete description of the uses and disclosures of my protected health information and my rights with respect to my medical information. I understand that Metro Anesthesia & Pain Management has the right to revise its privacy practice and to amend the Notice. I have been informed that in the event Metro Anesthesia & Pain Management revises it privacy practices, a revised notice will be posted at 2459 East Euclid Suite B, Des Moines, IA and 5901 Westown Pkwy. Suite 210, West Des Moines, IA, and that I may obtain a current Notice at any time from either location.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. I understand that I may revoke this Consent only in a writing sent certified mail to Metro Anesthesia & Pain Management. I further understand that Metro Anesthesia & Pain Management does not have to agree to such restrictions. If Metro Anesthesia & Pain Management agrees to the restriction in writing, it is binding. I understand that the revocation or restriction will be effective only upon receipt and will not apply to information that has already been used or disclosed in accordance with this Consent. I understand that the revocation or restriction will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ _____

Signature of Patient/Representative and Date
Relationship if applicable _____

Patient Financial Responsibility for Copayments and Other Amounts

My signature below forms a binding agreement between me and Metro Anesthesia & Pain Management. I agree to pay any required copayment, or other amounts not covered by insurance, at the time such payment is requested.

_____ _____

Signature of Patient/Representative and Date
Relationship if applicable _____