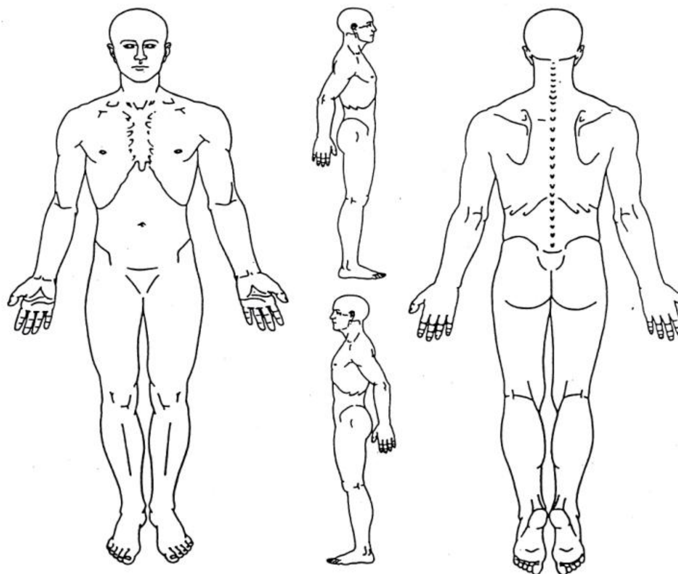
Case History II

List surgical operations and dates____

List medications____

Please draw the location of your pain or discomfort on the images below and use the symbols shown in the key at the left to represent the type(s) of pain: Example: "S" represents "Sharp pain, "T" Tingling, etc.

Key
D = Dull
B = Burning
N = Numb
S = Sharp
T = Tingling (pins/needles)
C = Cramping/Spasm



On the scales below, draw a vertical line representing your pain or discomfort

Rate the pain you have right ***now:***
No Pain ———————————————— Unbearable Pain

Rate your pain at it's ***best*** in the past
No Pain ———————————————— Unbearable Pain

Rate your ***average*** pain in the past week:
No Pain ———————————————— Unbearable Pain

Rate your ***worst*** pain in the past week:
No Pain ———————————————— Unbearable Pain

OTHER SYMPTOMS
( ) Chest Pain
( ) Dizziness/light headedness
( ) Swelling in ankles or feet
( ) Cold hands/feet
( ) Shortness of breath
( ) Nausea or stomach pain
( ) Tickling or lump in throat
( ) Eye or vision changes
( ) Loss of hearing
( ) Ringing in ears
( ) Loss of grip strength
( ) Nervousness
( ) Depressed
( ) Loss of memory
( ) Feeling run down
( ) Irritable
( ) Fatigue

WOMEN ONLY:
( ) Menstrual pain ________(where)
( ) Cramping ( ) Irregularity
( ) Cycle _________days
( ) Birth control ( ) Hysterectomy
( ) Discharge ( ) Menopause
Other__________________
( ) Are you or do you think you are pregnant?

MEN ONLY:
( ) Urinary frequency ( ) Night urination
( ) Difficulty in starting ( ) Prostate pain/swelling

LIFESTYLE
Hours sitting at desk/commuting______
How long at one time? ________
Are you a:
( ) side ( ) back ( ) stomach sleeper
What size pillow do you use?
( ) thin ( ) medium ( ) thick
Do you exercise regularly? Y / N
If yes, type_________________________
Normal sleep /hours_____
Sleep loss _____hrs. per night
Weight loss _____lbs.
Weight gain _____ lbs.
Coffee _____ cups per day
Tea ____ cups per day
Cigarettes ____ packs per day
Alcohol ____ glasses per day
Other ______________________________

Do you have any other problems that the doctor should be told

Patient Name____ Date_______________