



COMPREHENSIVE
Pain Management Center

Annu H. Navani, M.D., Q.M.E.
Board Certified in Pain Management & Anesthesia
Ph: 408.356.5292
Fax: 408.356.5307

PAIN HISTORY

What is the purpose of your visit? _____

Who has referred you? _____

Where is the pain located? _____

When did the pain start? _____

How did the pain first start? (Circle one)

- o Suddenly Gradually Cumulative
- o Accident Trauma Fall Injured at work Sports

Is this a Workers Compensation injury? Yes No

What is the level of pain today if 0 is no pain and 10 is worst pain: ____/10

Is your pain constant or intermittent?

Nature of pain: dull achy sharp shooting burning pins/needles

What makes you pain worse?

What makes your pain better?

In the last 12 months how many times have you visited the ER for treatment of your Pain?

Is there a personal injury claim or litigation in relation to the current pain?

Have these activities been effected because of your pain: list yes or no

| | | | |
|------------------|--|---------------|--|
| Household chores | | Depression | |
| Office Work | | Anxiety | |
| Drive | | Mood | |
| Walk/Run | | Appetite | |
| Sports | | Sleep | |
| Concentration | | Relationships | |

What treatments have you tried in the past? List if it was effective.

CURRENT MEDICATIONS

| Name of Medication | Date Started | Prescribing Physician | Strength | Number of pills/day | Does it help? (yes/no) |
|--------------------|--------------|-----------------------|----------|---------------------|------------------------|
| | | | | | |
| | | | | | |
| | | | | | |

ALLERGIES: _____

PAST SURGICAL HISTORY:

| Type | Date | Surgeon |
|------|------|---------|
| | | |
| | | |
| | | |

PAST MEDICAL, FAMILY HISTORY AND REVIEW OF SYSTEMS: (check box)

| | You | Family | | You | Family | | You | Family |
|----------------|-----|--------|---------------------|-----|--------|---------------------------|-----|--------|
| Stroke | | | Diabetes | | | Suicide ideation/attempts | | |
| Seizures | | | High Blood Pressure | | | Depression/Bipolar | | |
| Heart | | | Thyroid | | | Mental Disorders | | |
| Lungs | | | Bleeding/Anemia | | | Alcohol/Drug problems | | |
| Liver | | | Stomach/Bowel | | | State/ SS disability | | |
| Kidney/Bladder | | | Fibromyalgia | | | Other | | |
| Cancer | | | Gout | | | | | |
| Migraines | | | Arthritis | | | | | |

PERSONAL AND SOCIAL HISTORY: Circle Yes/No. Please offer detailed answer if yes.

Do you work? Yes/No; Occupation: _____ Employer: _____

What is your highest level of education? _____

Are you () Single () Married () Separated () Divorced () Widowed

Do you have children? How many? _____ Ages _____

Who do you live with? _____

Do you smoke? Yes/No; # of packs/day _____

Do you drink alcohol? Yes/No; how much? _____

Do you use recreational drugs? Yes/No; if yes, please elaborate _____

Have you ever abused drugs or alcohol in the past? Yes/No

Have you ever been treated at a drug or alcohol rehabilitation center? Yes/No

PAIN DIAGRAM:

