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

COMPREHENSIVE
Pain Management Center
Defining Excellence in Pain Management

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)

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

Is this is 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**

_____
_____
_____
_____

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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:

2577 Samaritan Dr. Suite 705 San Jose, CA 95124