Welcome!

Patient's ID sticker will go here

Anesthesiology and Critical Care Medicine
Division of Pain Medicine
601 N. Caroline St. • Suite 3062 • Baltimore, MD 21287-0812
410-955-PAIN • Fax 410-502-2390

Confidential Blaustein Interventional Pain Treatment Center Health Questionnaire

Thank you for choosing the Johns Hopkins Blaustein Pain Treatment Center for your healthcare needs.

GETTING READY FOR YOUR VISIT

On your first visit, please bring any relevant medical records, X-rays, CT or MRI scans, medication bottles and other medical information related to the problem for which you are being seen.

Please complete the attached questionnaire **before** your appointment. It is confidential and will become part of your medical record. It asks for information about your current problems, and past medical history. This form will give your doctor a better understanding of your problem and will allow him or her to spend more time discussing treatment plans with you.

We value you as a patient and are providing the following information about clinic policies in order to assist us in delivering your healthcare needs.

YOUR CARE TEAM

Our clinic is part of a teaching institution and your care will be coordinated by a team of attending physicians, fellows and residents. They are all physicians who have training in managing patients with pain.

During your visit, you will first have your history and physical taken by the resident or fellow. Then the physician will present your case to the attending doctor, including the review of medical records, interpretation of radiology reports and scans, and the evaluation of your exam. Then the team will work with you to determine the best possible treatment plan.

CANCELLATION POLICY

We have established the following policies in order to provide every patient care as quickly as possible.

Consult Appointments: As a new patient, we will allow you to reschedule your consult appointment one time. After two cancellations and/or no-shows, you will not be allowed to reschedule with our clinic.

Existing Patients: Once you have become a patient of the clinic, we ask that you make your appointments carefully to ensure you are able to keep them. After three cancellations and/or no-shows you may be discharged from the clinic. This is based on physician review of your case.

LATE POLICY

If you arrive past the indicated **"Arrival Time"** on your enclosed letter, you may be asked to reschedule. We ask that you arrive 30 minutes before your scheduled appointment time in order to allow time for registration.

PRESCRIPTION DRUGS

Please be aware that we may **not** be able to provide you with medications. If you have been prescribed a medication by another physician, it is the responsibility of that physician to continue providing you with that medication. We are not responsible for continuing a medication that another physician has prescribed.

We also ask that you bring all pill bottles for the medications you are currently taking to your visit. Our physicians will determine the best possible treatment plan for you, but this may not include the continuation of current prescriptions.

PHYSICIAN PHONE CALLS

When calling the clinic to speak with your physician, a nurse, a resident and/or a fellow that is working with your doctor may return your call. These clinicians all have access to your records. Calls will be returned as quickly as possible, usually within 24 hours. Since we are not an urgent care clinic, if you have an emergency, we advise that you go to your nearest emergency room.

Thank you for choosing The Johns Hopkins Blaustein Pain Treatment Center for your care. We look forward to working with you.

Patient's ID sticker will go here

Patient's Name ______________________________

Date of Birth ______________________________ Sex: ☐ Male ☐ Female

City ______________________ State __________ ZIP __________

Daytime Phone ______________________ Evening Phone ______________________

Name of Primary Care Physician ______________________________

Address ______________________________

City ______________________ State __________ ZIP __________

Phone ______________________ Fax ______________________

List other physicians that your records should be sent to:

Doctor ______________________	Doctor ______________________
Address ______________________	Address ______________________
City ______________________	City ______________________
State __________ Zip __________	State __________ Zip __________
Phone __________ Fax __________	Phone __________ Fax __________

CAUSES OF YOUR PAIN Please answer all questions.

Event(s) surrounding the onset of your pain	Date Pain Began	Pain Intensity Today
______________________	__________	☐ Better ☐ Same ☐ Worse
______________________	__________	☐ Better ☐ Same ☐ Worse
______________________	__________	☐ Better ☐ Same ☐ Worse
______________________	__________	☐ Better ☐ Same ☐ Worse

I believe my pain is due to (write description on line provided):

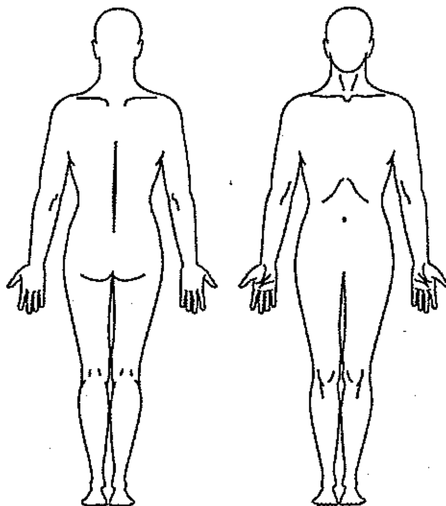
☐ The effects of treatment (e.g., medication, surgery, radiation, prosthetic device) ______________________

☐ My primary disease (meaning the disease currently being treated and evaluated) ______________________

☐ A medical condition unrelated to my primary disease (e.g., arthritis) ______________________

PAIN DESCRIPTION

On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



Check all the things that make your pain worse:

☐ sitting ☐ standing ☐ rest ☐ heat ☐ cold ☐ walking
☐ exercise ☐ sex ☐ touch ☐ other ______________________

Check all the things that make your pain better:

☐ sitting ☐ standing ☐ rest ☐ heat ☐ cold ☐ walking
☐ exercise ☐ sex ☐ touch ☐ other ______________________

Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, toothaches). Have you had pain other than these everyday kinds of pain during the last week?

☐ No ☐ Yes

If yes, what kind? ______________________

Please rate your pain by checking the one number that best describes your pain at its ***worst* in the last week.**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Worse Pain You Can Imagine

PAIN DESCRIPTION continued

Please rate your pain by checking the one number that best describes your pain at its ***least*** **last week.**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Worse Pain You Can Imagine

Please rate your pain by checking the one number that best describes your **pain on the *average.***

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Worse Pain 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 — Worse Pain You Can Imagine

For each of the following, check Yes or No if that word applies to your pain.

Aching	☐ No	☐ Yes
Throbbing	☐ No	☐ Yes
Shooting	☐ No	☐ Yes
Stabbing	☐ No	☐ Yes
Gnawing	☐ No	☐ Yes
Sharp	☐ No	☐ Yes
Tender	☐ No	☐ Yes
Burning	☐ No	☐ Yes
Exhausting	☐ No	☐ Yes
Tiring	☐ No	☐ Yes
Penetrating	☐ No	☐ Yes
Nagging	☐ No	☐ Yes
Numb	☐ No	☐ Yes
Miserable	☐ No	☐ Yes
Unbearable	☐ No	☐ Yes

Check the one number that describes how, during the past week, pain has interfered with your:

General Activity

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

Mood

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

Walking Ability

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

Normal Work (include both work outside the home and housework)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

Relations with other people

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

Sleep

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

Enjoyment of Life

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

PAIN TREATMENT(S)

How many physicians have been involved in the treatment of your pain?

☐ 0-3 ☐ 4-5 ☐ 6-10 ☐ 11-15 ☐ 16 or more

How many emergency room visits have you had in the last year for pain?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

Check all other methods you use to relieve your pain:

☐ warm compresses ☐ distraction
☐ cold compresses ☐ biofeedback
☐ relaxation techniques ☐ hypnosis

In the last week, how much **relief** have pain treatments or medications provided? Please check the one percentage that most shows how much relief you have received.

☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

No Relief — Complete Relief

Patient's ID sticker will go here

PAIN TREATMENT(S) continued

Check the nerve blocks, injections or procedures that have been performed. If you've had a procedure, but you don't remember what it was called, please choose "other."

	How Many	Date(s) Performed
☐ Cervical (neck) epidural steroid injection	______	______________________
☐ Lumbar epidural steroid injection	______	______________________
☐ Caudal epidural steroid injection	______	______________________
☐ Facet joint block	______	______________________
☐ Facet joint denervation	______	______________________
☐ Stellate ganglion block	______	______________________
☐ Lumbar sympathetic block	______	______________________
☐ Trigger point injection	______	______________________
☐ Discogram	______	______________________
☐ Occipital nerve block	______	______________________
☐ Intercostal nerve block	______	______________________
☐ Spinal cord stimulator	______	______________________
☐ Intrathecal pump	______	______________________
☐ Other__________	______	______________________

PAIN MEDICATION

Do you have some form of pain now that requires medication each and every day? ☐ No ☐ Yes

Did you take pain medications in the last 7 days? ☐ No ☐ Yes

If you take pain medication, how many hours does it take before the pain returns? Check one.

- ☐ Pain medication doesn't help at all
- ☐ One hour
- ☐ Two hours
- ☐ Three hours
- ☐ Four hours
- ☐ Five to twelve hours
- ☐ More than twelve hours
- ☐ I do not take pain medication

Check how you prefer to take pain medicine:
☐ On a regular basis ☐ Only when necessary
☐ Do not take pain medication

How do you take pain medicine over a 24-hour period?
☐ Not every day ☐ 1 to 2 times per day
☐ 3 to 4 times per day ☐ 5 to 6 times per day
☐ More than 6 times per day

Do you feel you need a stronger type of pain medication?
☐ No ☐ Yes ☐ Uncertain

Do you feel you need to take more of the pain medication than your doctor has prescribed?
☐ No ☐ Yes ☐ Uncertain

Do you feel you need to receive further information about your pain medication?
☐ No ☐ Yes

PAST PAIN MEDICATION: Have you ever taken the following pain-related medications in the PAST? Do not list current medications on this page.

	No	***Yes***	***Why did you stop?***		
Acetaminophen (Tylenol)	☐	☐	☐ Side effect(s)__________	☐ Didn't work	☐ Stopped working
Actiq (fentanyl)	☐	☐	☐ Side effect(s)__________	☐ Didn't work	☐ Stopped working
Amitriptyline (Elavil)	☐	☐	☐ Side effect(s)__________	☐ Didn't work	☐ Stopped working
Butorphanol (Stadol)	☐	☐	☐ Side effect(s)__________	☐ Didn't work	☐ Stopped working
Capsaicin cream	☐	☐	☐ Side effect(s)__________	☐ Didn't work	☐ Stopped working
Celebrex	☐	☐	☐ Side effect(s)__________	☐ Didn't work	☐ Stopped working
Codeine (Tylenol #3)	☐	☐	☐ Side effect(s)__________	☐ Didn't work	☐ Stopped working

Patient's ID sticker will go here

PAST PAIN MEDICATION continued: Have you ever taken the following pain-related medications in the PAST? Do not list current medications on this page.

	No	*Yes*	*Why did you stop?*		
Cymbalta	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Demerol	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Depokote	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Desipramine	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Dextromethorphan	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Dilaudid	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Doxepin (Sinequan)	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Effexor	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Fentanyl Patch	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Fentora (fentanyl)	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Flexeril	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Hydrocodone (Vicodin)	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Ibuprofen (Motrin, Advil)	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Imipramine	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Kadian	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Lamictal	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Lidoderm Patch	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Lyrica	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Methadone (Dolophine)	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Mobic (meloxicam)	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Morphine (MS Contin)	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Neurontin	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Nortriptyline (Pamelor)	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Nucynta (tapentadol)	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Opana (oxymorphone)	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Oxycodone (Percocet)	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Oxycontin	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Pentazocine HCl (Talwin)	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Propoxyphene (Darvocet)	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Prozac/Paxil	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Skelaxin	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Soma	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Suboxone (buprenorphine)	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Tegretol	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Topamax	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Toradol (Ketorolac)	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Trazadone (Desyrel)	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Ultram (Tramadol)	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Valium	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Voltaren gel	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Wellbutrin	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Xanax	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working
Zanaflex	☐	☐	☐ Side effect(s)________	☐ Didn't work	☐ Stopped working

Patient's ID sticker will go here

HOSPITALIZATION AND SURGICAL HISTORY

Have you ever had surgery or been hospitalized? ☐ No ☐ Yes *If yes,* list each below and give year.

Reason for Surgery or Hospitalization	Year	Reason for Surgery or Hospitalization	Year

REVIEW OF SYSTEMS

Please review the list below. If you have currently, or have ever had a problem in any of these areas, please check "Yes" and explain in the space below. If not, please check "No."

General/ENT

- Skin ☐ No ☐ Yes ____
- Head ☐ No ☐ Yes ____
- Eyes ☐ No ☐ Yes ____
- Ears ☐ No ☐ Yes ____
- Nose/Sinus ☐ No ☐ Yes ____

Lungs and Chest

- Asthma ☐ No ☐ Yes ____
- Emphysema ☐ No ☐ Yes ____
- Lung Cancer ☐ No ☐ Yes ____
- Pneumonia ☐ No ☐ Yes ____

Heart and Blood Vessels

- Heart attack ☐ No ☐ Yes ____
- Angina (chest pain) ☐ No ☐ Yes ____
- High blood pressure ☐ No ☐ Yes ____
- Irregular heartbeat ☐ No ☐ Yes ____
- Poor circulation in legs ☐ No ☐ Yes ____
- Blood clot in legs ☐ No ☐ Yes ____
- Blood clot in lungs ☐ No ☐ Yes ____
- Sores that won't heal ☐ No ☐ Yes ____
- Swellings in legs ☐ No ☐ Yes ____

Urinary/Genital

- Kidney stones ☐ No ☐ Yes ____
- Painful urination ☐ No ☐ Yes ____
- Urinary dribbling ☐ No ☐ Yes ____
- Difficult urinating ☐ No ☐ Yes ____
- Urinary infections ☐ No ☐ Yes ____
- Sexually transmitted diseases ☐ No ☐ Yes ____
- Incontinence ☐ No ☐ Yes ____

Bones/Joints

- Broken bones ☐ No ☐ Yes ____
- Arthritis ☐ No ☐ Yes ____
- Amputations ☐ No ☐ Yes ____

Nerves/Brain

- Sensation loss ☐ No ☐ Yes ____
- Fainting ☐ No ☐ Yes ____
- Seizures ☐ No ☐ Yes ____
- Stroke ☐ No ☐ Yes ____
- Spinal cord injury ☐ No ☐ Yes ____
- Multiple sclerosis ☐ No ☐ Yes ____
- Headache/Migraine ☐ No ☐ Yes ____
- Coordination loss ☐ No ☐ Yes ____
- Weakness/Paralysis ☐ No ☐ Yes ____
- Disc problems ☐ No ☐ Yes ____

Blood

- Anemia ("low blood") ☐ No ☐ Yes ____
- Abnormal clotting ☐ No ☐ Yes ____
- Easy bruising/bleeding ☐ No ☐ Yes ____
- Transfusions ☐ No ☐ Yes ____

Stomach/Esophagus/Intestines

- Heartburn ☐ No ☐ Yes ____
- Nausea/Vomiting ☐ No ☐ Yes ____
- Constipation/Diarrhea ☐ No ☐ Yes ____
- Hemorrhoids ☐ No ☐ Yes ____
- Gallstones ☐ No ☐ Yes ____
- Changes in stool ☐ No ☐ Yes ____
- Hernia ☐ No ☐ Yes ____
- Ulcers ☐ No ☐ Yes ____
- Polyps ☐ No ☐ Yes ____

Patient's ID sticker will go here

REVIEW OF SYSTEMS continued

Psychology/Psychiatry

Depression ☐ No ☐ Yes ____________
Anxiety ☐ No ☐ Yes ____________
Panic attacks ☐ No ☐ Yes ____________
Suicidal thoughts ☐ No ☐ Yes ____________
Sleep disturbance ☐ No ☐ Yes ____________
Irritability ☐ No ☐ Yes ____________
Mood swings ☐ No ☐ Yes ____________
Counseling ☐ No ☐ Yes ____________

Endocrine

Diabetes ☐ No ☐ Yes ____________
Heat/Cold Intolerance ☐ No ☐ Yes ____________
Weight Loss/Gain ☐ No ☐ Yes ____________
Change in appetite ☐ No ☐ Yes ____________
Change in sexual desire ☐ No ☐ Yes ____________

Cancer

If yes, please list type(s) ☐ No ☐ Yes ____________

Male

Erectile Dysfunction ☐ No ☐ Yes ____________

Female

Abnormal vaginal bleeding, discharge, or pain ☐ No ☐ Yes ____________
Breast lumps, discharge ☐ No ☐ Yes ____________
Change in menstrual cycle ☐ No ☐ Yes ____________

WORK

Are you currently employed? ☐ No ☐ Yes
If yes: what do you do? ____________
How many hours per day? ____________
If no: How long have you been out of work? ____________
What was your occupation? ____________
How do you spend your day? ____________
Is unemployment due to pain? ☐ No ☐ Yes
Have you ever been in the military? ☐ No ☐ Yes
Are you able to do household chores? ☐ No ☐ Yes
Explain ____________

INCOME

Are you currently on Disability? ☐ No ☐ Yes
Are you applying for Disability? ☐ No ☐ Yes
Are you receiving Worker's Compensation? ☐ No ☐ Yes
Are you applying for Worker's Compensation? ☐ No ☐ Yes
Do you have litigation pending against an employer or individual due to an accident or injury? ☐ No ☐ Yes

HOUSEHOLD

List your hobbies ____________

Your present marital status ☐ Single ☐ Married
☐ Separated ☐ Divorced ☐ Widowed
Do you have children? ☐ No ☐ Yes
If yes, how many? ____________
If yes, list ages ____________

DAILY ACTIVITIES

List exercises you participate in ____________

What is your activity level?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Inactive — Very Active

SEXUAL ACTIVITIES

Are you sexually active? ☐ No ☐ Yes *If yes,* answer below.
What is your present satisfaction regarding your sexual activity?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Inactive — Very Active

SPIRITUALITY

Do you have a religious affiliation? ☐ No ☐ Yes
What is your involvement in religious activities?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Inactive — Very Active

EDUCATION

Check highest level of education completed.
☐ Grade school ☐ High school ☐ Junior college
☐ College ☐ Trade school ☐ Graduate School
☐ Professional School

Patient's ID sticker will go here

FAMILY MEDICAL HISTORY

Please list any major illnesses in your family, including stroke, cancer, high blood pressure, diabetes, chronic pain, etc.

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

SOCIAL

What is your involvement in social activities?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No involvement — Actively Involved

Is this a change since the onset of your pain? ☐ No ☐ Yes

Do you currently smoke? ☐ No ☐ Yes

If yes: packs per day?_____ for how many years? _________

Were you a smoker in the past? ☐ No ☐ Yes

If yes: for how many years?_____ year you quit?__________

Do you use alcohol? ☐ No ☐ Yes

If yes, on average, how many drinks do you have **per week?**

☐ 3 or less ☐ 4-7 ☐ 8-12 ☐ 13 or more

Was there ever a time in your life when you may have had an alcohol problem? ☐ No ☐ Yes

Did you ever, or do you now, use street drugs? ☐ No ☐ Yes

If yes, list ______________________________

____

Have you ever been addicted to prescription drugs? ☐ No ☐ Yes

Does anybody in your family have a history of drug misuse/addiction? ☐ No ☐ Yes

Have you ever been in a treatment program for alcohol or drug abuse? ☐ No ☐ Yes

If yes, explain ______________________________

____

____

CURRENT OPIOID THERAPY If applicable (for example, percocet, oxycontin, duragesic patch)

What percent relief do your opioids (narcotics) provide?

☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Do you have any side effects from your opioids? ☐ No ☐ Yes

If yes, check all that apply:

☐ Constipation ☐ Itching ☐ Dry mouth ☐ Nausea

☐ Erectile problems ☐ Menstrual change

☐ Vomiting ☐ Dizziness ☐ Lightheadedness

☐ Sleepiness ☐ Problems urinating

☐ Appetite change ☐ Tooth decay

Are you any more functional from using opioids? ☐ No ☐ Yes

If yes, how?______________________________

Are your opioids kept in a secure place? ☐ No ☐ Yes

Where? ______________________________

Do you feel that your mood has improved from opioid therapy? ☐ No ☐ Yes

If yes, how?______________________________

Has your quality of life improved? ☐ No ☐ Yes

If yes, how?______________________________

Name and phone number of pharmacy listed on opioid bottle

____

Name of doctor currently prescribing opiods

____

Prescribing doctor's phone number

____

EXPECTATIONS

What are you hoping to gain from your visit with the Blaustein Interventional Pain Treatment Center?

Circle the percentage of pain relief you would feel would make your treatment worthwhile.

☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

JOHNS HOPKINS
MEDICINE

THE JOHNS HOPKINS HOSPITAL
600 NORTH WOLFE STREET
BALTIMORE, MD 21287

Outpatient Medication List

Directions: Update and give a copy of this list to the patient with each outpatient visit.
Do not use abbreviations.

❑ Patient taking no medication regularly and none in the past 72 hours.

MEDICATIONS (include over-the-counter and herbal medications)	DOSE (e.g., strength, # of pills or drops)	ROUTE (e.g., by mouth, inhaled, on skin)	FREQUENCY (how often)
Example: Vitamin C	*250 mg*	*By mouth*	*Once a day*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

New Medications – Please enter all new medications below.

MEDICATION	DOSE	ROUTE	FREQUENCY	COMMENT
1.				
2.				
3.				
4.				

Please use additional sheet for more medications.

If you have questions about any of your medications, please contact the person who prescribed them.

Reviewed by (Physician / Resident / PA or Nurse's Signature) ____________________

Date ____________________