Pain Management
Initial Consultation

Patient Name:

DOB:

MR#:

Allergies

Med. Reactions/Allergies □ NKA □ NKDA □ NKA to tape □ NKA to latex □ NKA to IV contrast □ NKA foods

Substance	Reaction	Substance	Reaction

Medications

Anticoagulant Medications: (Coumadin, Warfarin, Low Molecular weight Heparin, Lovenox, Fragmin, Innohep) □ Other □ None

Antiplatelet Medications: (Plavix, Platel, Ticlid) □ Other □ None

Medication: (List all current medications including over the counter medications and herbs with doses/schedule)

____
____
____
____
____

Medical History

Have you ever Had:

Yes	No		Yes	No		Yes	No	
		Aids/HIV Positive			Emphysema/Bronchitis			Osteoporosis
		Anemia			Epilepsy			Psychiatric/Emotional Problems
		Anxiety/Depression			Gall Bladder Disease			Sickle Cell Trait or Disease
		Arthritis			Glaucoma			Ulcers/Gastroesaphogeal Reflux
		Asthma			Heart Disease			Stroke
		Bleeding Disorders			Hepatitis/Liver Disease			Thyroid Disease/Other Gland Problems
		Cancer/Lymphoma Leukemia			High Blood Pressure			Tuberculosis/recent infection History of MRSA (Staph) infection
		Depression			High Cholesterol			Blood Clots/Bleeding Disorders
		Diabetes			Kidney Disease			Hospitalization
					Migraines/Headaches			Other:________________________

Surgical History

List type of Surgery & Year Performed: □ None

1.
2.
3.
4.
5.
6.
7.
8.
9.

Hospital Admissions

List Non-Surgical Hospitalization and Reason for them: □ None

1.
2.
3.
4.
5.
6.
7.
8.
9.

Pain Management
Initial Consultation

Patient Name:

DOB:

MR#:

Social History

Presently Employed ☐Yes ☐ No Occupation or Previous Occupation:___________________________________

Tobacco use: ☐Yes ☐ No ____Packs/Day_____No. of Years Marital Status:_______________ Children ☐Yes ☐ No

Alcohol Use: ☐Yes ☐ No How Often (amount/type):________________________________ Street Drugs: ☐Yes ☐ No

Skin: ☐ **No significant History**
☐ Psoriasis ☐ Eczema ☐ Acne ☐ Other:_______

Hematologic: ☐ **No significant History**
☐ Easy Bruising ☐ Easy Bleeding ☐ Clots ☐ Anemia

Review of Systems

HEENT: ☐ **No significant History**

☐ Tinnitus ☐ Dysphasia ☐ Glasses/Contact Lenses
☐ Visual Disturbances ☐ Hearing Aid ☐ Hair Piece/Weave
☐ Discharge ☐ Dentures ☐ Other:_________________________________

Neurologic: ☐ **No significant History**

☐ Headaches ☐ Memory Loss ☐ Back/Neck Pain
☐ Dizziness ☐ Anxiety/Depression ☐ Numbness
☐ Paralysis ☐ Fatigue ☐ Weakness
☐Seizures ☐ Other:___________________________________

Cardiovascular: ☐ **No significant History**

☐ Chest Pain ☐ HTN ☐ AICD
☐ MI ☐ Palpitations ☐Angina
☐ Syncope ☐Pacemaker ☐ Other:_____________________________

Review of Systems

Gastrointestinal: ☐ **No significant History** ☐ Abdominal Pain ☐ Reflux ☐ Jaundice
☐ Change of Appetite ☐ Change in Bowel Habits ☐ Nausea/Vomiting
☐ Weight Change ☐ Other:____

Urinary: ☐ **No significant History**
☐ Dysuria ☐ Polyuria ☐ Renal Failure
☐ Frequency/Hesitancy ☐ Hemaluria ☐ Other:________

OB/GYN: ☐ **No significant History**
☐ Dysmenorrheal ☐ Possibility of Pregnancy
☐ Cancer ☐ Other:______________________

Endocrine: ☐ **No significant History**
☐ Heat or Cold Intolerance ☐ Polyuria ☐ Renal Failure
☐ Frequency/Hesitancy ☐ Hematuria ☐ Other:_______

Immunological: ☐ **No significant History**
☐ Scleroderma ☐ Rheumatoid Arthritis
☐ Lupus

Pulmonary: ☐ **No significant History** ☐ Pneumonia ☐ Orthopnea ☐ SOB ☐ TB
☐ Asthma ☐ Hemoptysia ☐ Cough ☐ DOE ☐ Emphysema

Musculoskeletal: ☐ **No significant History**
☐ Pain ☐ DVT ☐ Arthritis ☐ Swelling

Body Piercing: ☐Yes ☐ No Where:_______________
Prosthesis: ☐ Yes ☐ No Where:_______________

Family History

PLEASE CHECK THE BOX IF ANYONE IN YOUR FAMILY HAS THE FOLLOWING AND LIST WHICH FAMILY MEMBER.

Yes	No		Yes	No	
☐	☐	Birth Defects:___________________________	☐	☐	High Blood Pressure:______________________
☐	☐	Breast Disease:_________________________	☐	☐	High Cholesterol:_________________________
☐	☐	Cancer(Breast,Ovarian,Colon):____________	☐	☐	Osteoporosis:_____________________________
☐	☐	Diabetes:_______________________________	☐	☐	Stroke:__________________________________
☐	☐	Heart Attack before age 50:_______________	☐	☐	Bleeding Disorders:________________________
☐	☐	Heart Disease:___________________________	☐	☐	Other:___________________________________

Pain Management
Initial Consultation

Patient Name:

DOB:

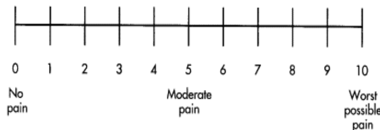
MR#:

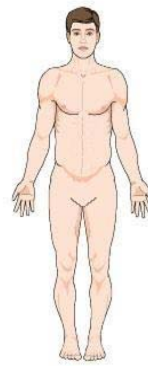
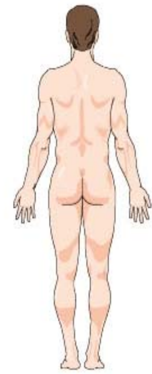
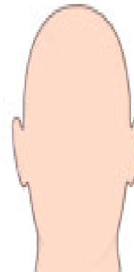
Pain History

Location of Pain or Other Symptoms:
On Diagram indicate pain location

Circle type of Pain/Symptom
Pressure
Burning
Achy
Stabbing
Numbness
Pins & Needles

Pain Intensity:



Location of Pain:______________________________

Other Related Symptoms:______________________________
____

What Makes Pain Better/Worse:______________________________
____
____

Pain History, (When, How did your pain begin, has it changes): ______________________________
____
____
____
____
____

Procedures and Medication tried in the Past: ______________________________
____
____
____
____
____

Previous Pain Doctor:______________________________

What are your goals: ______________________________

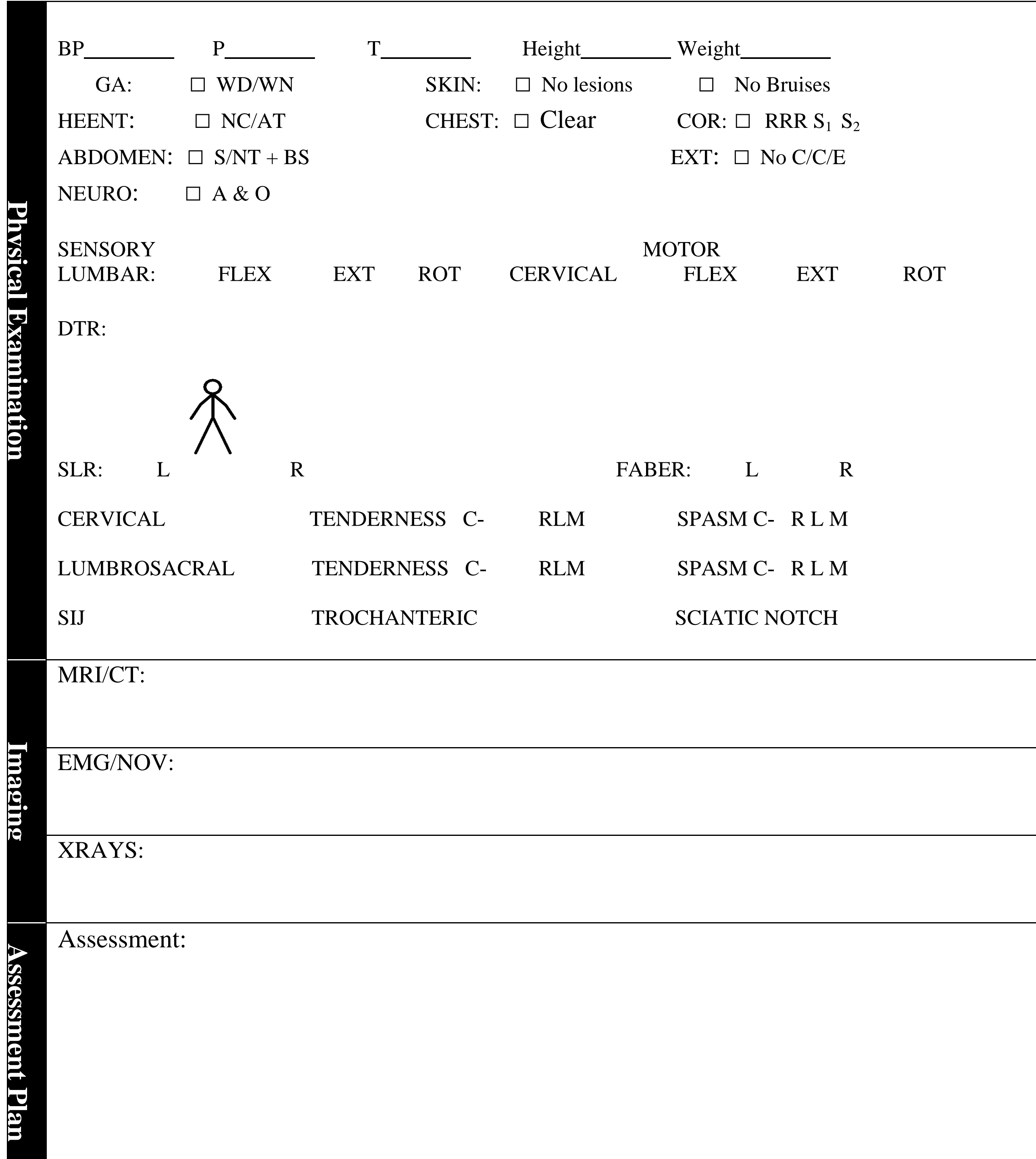
What would you do if your pain decreased: ______________________________

Patient Name:

DOB:

MR#:

PAIN MANAGEMENT INITIAL CONSULTATION



Physical Examination

BP________ P________ T________ Height________ Weight________

GA: ☐ WD/WN SKIN: ☐ No lesions ☐ No Bruises

HEENT: ☐ NC/AT CHEST: ☐ Clear COR: ☐ RRR S_1 S_2

ABDOMEN: ☐ S/NT + BS EXT: ☐ No C/C/E

NEURO: ☐ A & O

SENSORY MOTOR

LUMBAR: FLEX EXT ROT CERVICAL FLEX EXT ROT

DTR:

SLR: L R FABER: L R

CERVICAL TENDERNESS C- RLM SPASM C- R L M

LUMBROSACRAL TENDERNESS C- RLM SPASM C- R L M

SIJ TROCHANTERIC SCIATIC NOTCH

Imaging

MRI/CT:

EMG/NOV:

XRAYS:

Assessment Plan

Assessment:

Dr. Bruce H. Levin
Interventional Pain Management
Board & Subspecialty Board Certified

1. I consent Dr. Bruce Levin, MD or another doctor he may designate to perform upon me the following operation, procedure and/or medical treatment with or without Fluroscopic, Ultrasound, CT, or MRI guidance:

Cervical Thoracic Lumbar Facet injections of steroid and local anesthetic
Levels:

Cervical Thoracic Lumbar Transforaminal epidural injections of steroid and local anesthetic.
Levels:

Other:

2. The information listed below has been explained to me about the operation, procedure and/or medical treatment.

The nature and extent of the operation, procedure and/or treatment.

• Other types of treatment I could choose and what may happen if I do not have treatment.

• Possible complications include, but are not limited to:

Death, infection, headache, drug or other allergic or adverse reactions to steroids or local anesthetic effects, respiratory arrest, heart attack, abscess, collapsed lung, organ perforation, stroke, seizure, paralysis, weakness, nerve damage, new or increased pain or worsening of symptoms, bleeding, blood clot, blood vessel damage, occlusion or dissection, disability, exacerbation of other medical conditions, spinal cord injury, total spinal, vegetative state, fetal damage or death if pregnant.

The information was provided to me in terms that I understand. I am aware that the practice of medicine is not an exact science. I agree that no guarantee of results, success or cure has been given to me.

If, in the opinion of my doctor, any conditions are found in the course of the treatment which require additional or different treatment than those listed above, I allow my doctor to perform such procedures.

3. If I am prescribed an opioid or other medication, I understand it is my obligation to take them as directed. I understand that all treating physicians are to be made aware that I am receiving these medications and that I will not receive these medications from another physician. I

understand that I will be required to undergo random urine drug screens. It is my understanding that failure of these points will result in my discharge from the practice.

4. I understand that my doctors or others may need to administer conscious sedation injections and/or nerve blocks. If so, the possible complications of the type of planned anesthesia have been explained to me.

5. I consent to the taking and publication of any videographic or photographic reports in the course of treatment for inclusion in my medical record for treatment, education or other purposes.

6. I consent to the release of my Social Security number to the manufacturer of any surgical implants.

7. I understand that I can change my mind any time before this procedure and withdraw my consent in whole or in part by indicating on this form.

8. I understand that my doctor and those doctors that care for me in a hospital or outpatient facility may not be employees of agent of that facility. I will receive a separate bill for their services.

9. I certify that I read this consent form or it has been read to me. I understand the information in this form, and all of my questions were answered to my satisfaction.

__________________ ____

Date/Time Signature of Patient/Authorized Representative and Relationship

__________________ _______________________ ____________________________

Date/Time Witness to Signature Second Witness (if verbal consent)

I have explained the narue of the above treatment as well as reasonalb anticipated risks, complications, and alternative to such treatment.

__________________ ____

Date/Time Signature of Physician

I certify that I have had the above referenced procedures at the levels noted and have received and understood all postoperative instructions given to me.

__________________ ____

Date/Time Signature of Patient/Authorized Representative and Relationship