SOUTHLAKE PAIN CENTER
ERIC I. RAY, M.D.
GENERAL MEDICAL INFORMATION

Patient Name: _____ Date: _____

Current Pain:

Location: _____ Date Started: _____
Precipitated by (i.e. fall, mva) _____
Previous treatment: _____
Current pain level (0-10): _____

Past Medical History

Year **Illness**

_____ Heart Trouble: __ angina __ heart attack __ heart failure __heart mumur __valve disease
_____ High Blood Pressure
_____ Stroke
_____ Ulcers: ___stomach ___ duodenal ___ colon
_____ Diabetes (high blood sugar): ___ insulin dependent ___ non-insulin dependent
_____ Liver Disease: ___Hepatitis A ___Hepatitis B ___Cirrhosis ___other:_____
_____ Kidney Disease: ___stones ___infections ___other:_____
_____ Lung Disease: ___emphysema ___tuberculosis ___cancer ___asthma
_____ Blood Disorders: ___anemia ___leukemia ___bleeding tendency ___other:_____
_____ Eye Disease: ___glaucoma ___other:_____
_____ Arthritis: ___degenerative ___rheumatoid ___gout ___other:_____
_____ Cancer: ___ Type:_____
_____ Psychological Difficulties: ___depression ___psychosis ___other:_____
_____ High Cholesterol
_____ Thyroid Problems
_____ No Major Illnesses

Year **Surgeries**

_____ No Surgeries
_____ Tonsillectomy
_____ Appendectomy
_____ Gall Bladder
_____ Hernia
_____ Vasectomy
_____ Hysterectomy: ____total ___ partial
_____ Prostate
_____ Fractures: _____
_____ Cervical (neck)
_____ Lumbar (low back)
_____ Carpal Tunnel Releaswe
_____ Other: _____

Major Injuries

Please describe any major injuries resulting from trauma, automobile or cycle accidents, etc.

_____

Hospitalizations

Please describe any hospitalization you have had.

_____

Patient Name _____

Medications

Please list any medications (prescription or non-prescription) which you currently take.

Name	Strength	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Name of Medication(s): _____ Reaction: _____

_____ Check here if no known medication allergies.

Family Medical History

Mother: _____age

___ Alive and well.

___ Alive, suffers from: _____

___ Deceased

Father: _____age

___ Alive and well.

___ Alive, suffers from: _____

___ Deceased

Members of my family (brothers, sisters, grandparents, aunts, uncles) suffer from the following:
___stroke ___high blood pressure ___diabetes ___arthritis ___heart disease ___ lung disease
___back problems ___unknown ___cancer- type: _____

Social History

I am currently: ___married ___separated ___divorced ___widow/widower ___single.
I have: ___ children, ___ at home ___ living away from home.
I work as a _____. _____I am retired.
I drink: ___beer ___wine ___"hard drinks" ___none ___rarely ___socially ___dialy.
___I consider myself to drink too much ___ Others think I drink too much
I smoke: ___cigarettes ___pipe ___cigars (____ packs/day for ____years) ___none.
I use illicit drugs. Type: _____.
My recreational activities include: ___jogging ___bicycling ___sports ___other:_____.

Pharmacy Name:_____ Location: _____

Phone Number: _____