Emile M. Hiesiger, MD

Neurology and Interventional Pain Management

Patient Consultation Form

Date: _____ Time In: _____ Time Out: _____

Last Name: _____ Age: _____ Sex:

First Name: _____ Weight: _____ lbs. Height:

Street Address: _____

City, State: _____ Country: _____

Zip Code: _____ Cell Phone: _____

Telephone: _____ E-mail: _____

Occupation: _____

How were your referred to us? _____

Important! You **must** supply the full name, address, and telephone number of **BOTH your Referring Physician AND your Internist** (if different from the Referring Physician) in order for us to send medical reports to them. Thank you.

Referring Physician

Last Name: _____ First Name: _____

Street Address: _____

City, State: _____ Country: _____

Zip Code: _____

Telephone: _____ Email: _____

Internist

Last Name: _____ First Name: _____

Street Address: _____

City, State: _____ Country: _____

Zip Code: _____

Telephone: _____ Email: _____

Chief Complaint

Description of Pain

Site of pain: _____

Type of pain (aching, throbbing, burning, shooting, stabbing, pulling, cramp; dull, sharp; intermittent, constant, fluctuating in severity)

_____

_____

_____

When and how did this pain start:

_____

_____

_____

Prior treatment sought, result and date: (medication, surgery, physical therapy, TENS, acupuncture)

_____

_____

_____

Position or activity that exacerbates the pain:

_____

_____

Position or activity that relives the pain:

_____

_____

Does your pain interfere with your sleep? Yes ____ No ____

How has the pain evolved through present time:

_____

_____

_____

Present pain level (0 = no pain; 10 = severe pain) _____

ACTIVITY / LIFE STYLE

Have you had a weight loss or gain in the past year? Yes ____ No ____

If **YES,** specify how much, plus or minus _____

Did you ever smoke cigarettes? Yes ____ No ____

If **YES** how many a day? _____ For how many years? _____

Have you quit? Yes ____ No ____ If **YES**, how many years ago? _____

Do you use alcohol? Yes ____ No ____ If **YES,** # of drinks per week? _____

Do you use recreational drugs? Yes ____ No ____

If **YES**, name of drug(s): _____

_____

Are you athletically active? Yes ____ No ____

If **YES**, describe activity and frequency:

_____

_____

FAMILY HISTORY

Married ____ Single ____ Widowed ____ Divorced ____

Do you have children? Yes ____ No ____ If **YES,** how many? _____

Medical History of Your:

Mother _____

_____

_____

Father _____

_____

_____

Spouse _____

_____

_____

_____

FAMILY HISTORY (continued)

Children _____

Your Medical History (include year): _____

Your Surgical History (include year): _____

Your Mental Health History (include year): _____

Do you sleep through the night? Yes ____ No ____

If **NO,** why not? _____

ALLERGIES

Are you allergic to anything? Yes ____ No ____

If **YES,** Type Reaction

Have you ever taken Penicillin? Yes ____ No ____

Mycin? Yes ____ No ____

Sulfas? Yes ____ No ____

Do you eat shellfish? Yes ____ No ____

MEDICATIONS

Do you currently take medications? Yes ____ No ____

If **YES,** complete the following:

Medications	Strength	How Often Dosage / Frequency

YOUR MEDICAL HISTORY (continued)

Do you have or have you ever had	NO	YES	How Often	How long have you had this problem?	Additional Comments
Fainting Spells or Dizziness					
Severe Headaches					
Epilepsy or Convulsions					
Emotional problems (e.g. Depression)					
Pulmonary / Respiratory problems (e.g. shortness of breath) On Exertion					
At Rest					
Cataracts					
Chronic cough					
Tuberculosis					
Pneumonia					
Asthma					
Emphysema					
Heart disease / problem: Chest pain / Pressure					
Heart Attack					
Pacemaker					
Palpitations					
Rheumatic Fever					

YOUR MEDICAL HISTORY (continued)

Do you have or have you ever had	NO	YES	How Often	How long have you had this problem?	Additional Comments
High Blood Pressure					
Low Blood Pressure					
Poor Circulation					
Thyroid Disorder					
Leg Pain					
Arm Pain					
Stomach/Intestinal problems (e.g. frequent Indigestion/ nausea)					
Constipation					
Frequent Diarrhea					
Hemorrhoids					
Rectal Bleeding					
Ulcer					
Liver Disease					
Gallbladder Disease					
Incontinence: Accidentally losing your stool					
Accidentally losing your urine					
Kidney Problems (e.g. Kidney Failure)					

YOUR MEDICAL HISTORY (continued)

Bladder Problems (e.g. Bladder Disease)					
Stones					
Difficulty in Urination					
Diabetes					
Skin Problems					
Sexual Problems:					
Lack of Morning Erection					
Lack of Erection at Other Times					
Lack of Orgasm					
Lack of Ejaculation					
Other: **Radiation Therapy**					
Chemotherapy					
Cancer					
Immune System Disease					

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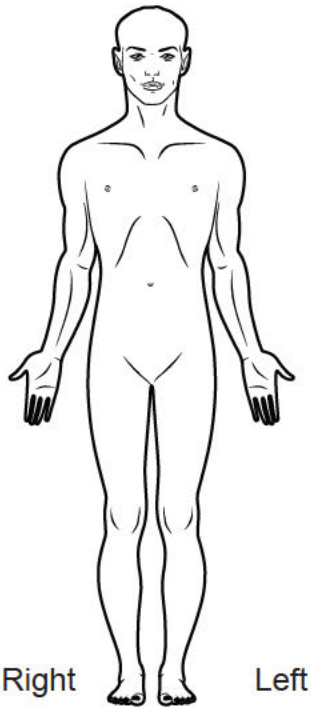
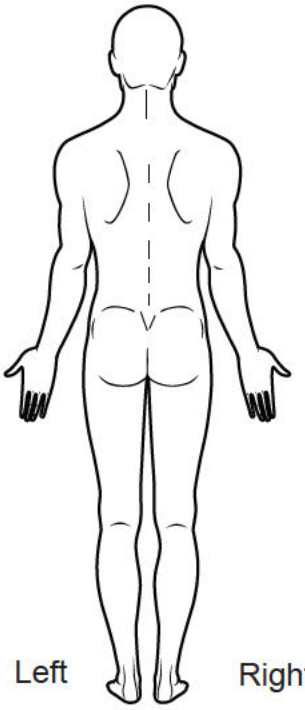
Please indicate on this diagram where your pain occurs by shading the painful parts of your body.



Right Left



Left Right

Right

Left

Patient Name: _____

Date: _____