John O. Dimowo, M.D.

CALIFORNIA ADVANCED PAIN INSTITUTE

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www.paindoc911.com

TREATMENT HISTORY

Please list all of the health care providers you have consulted regarding your pain and their treatment plan:

Orthopedic/Spine Surgeon ______________________
Neurologist ______________________
Rheumatologist ______________________
Pain Management ______________________
Primary Care ______________________
Physical Therapist ______________________
Acupuncturist ______________________
Occupational Medicine ______________________
Chiropractors ______________________
Alternative Medicine ______________________
Rehabilitation Medicine ______________________
Other ______________________

Please mark the medications that you have tried for your pain in the past and their effectiveness.(0 no help, 10 very helpful)

Name of medication	**Effectiveness (0 - 10)**
( ) Tylenol	
( ) NSAID's: Motrin / Advil / Ibuprofen, etc.	
( ) Opioids: Vicodin / Norco / Oxycodone, etc.	
( ) Oral Steroids / Medrol dose pack	
( ) Amitriptylene (Elavil), Nortriptylene (Pamelor), etc.	
( ) Neurontin / Topamax / Tegretol, etc.	
( ) Others	

Other General Medications

Name:	Dosage	Frequency

Past Medical History

Name of Illness:	Duration

Allergies: ______________________

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Treatment History (con't)

Past Surgical History

Name of Surgery	Date

Family History *(Please list the members of your family with chronic long term conditions, i.e., Diabetes, etc.)*

Social History

Occupation: Marital Status:

Education: On Disability: ( ) Yes ( )No

Use of Tobacco (type and how long) ______________________

Use of Alcohol (type and how long) ______________________

Use of Recreational Drugs (type and how long) ______________________

Review of Systems

Constitutional	( ) Fever	( ) Weight Loss	( ) Fatigue	
Eyes	( ) Blurred Vision	( ) Redness	( ) Double Vision	( ) Vision Loss
Ear/Nose/Throat	( ) Trouble hearing	( ) Ringing in the Ear	( ) Loss of Balance	( ) Dizziness/Vertigo
	( ) Ear Discharge			
Cardiovascular	( ) Chest Pain/Angina	( ) Irregular Heart Beat	( ) Limb Swelling	( ) Fainting
Respiratory	( ) Trouble Breathing	( ) Chronic cough	( ) Coughing Blood	
Gastrointestinal	( ) Indigestion	( ) Nausea	( ) Vomiting	( ) Diarrhea ( )Heart burn
	( ) Constipation	( ) Bloody stools		
Genitourinary	( ) Incontinence	( ) Pain on Urination	( ) Blood in Urine	
Musuloskeletal	( ) Muscle Pain	( ) Muscle Cramp	( ) Neck Pain	
	( ) Back Pain	( ) Joint Swelling	( ) Joint Pain	( ) Stiffness
Skin & Breast	( ) Numbness	( ) Hair Loss	( ) Discoloration	
Neurologic	( ) Headache	( ) Weakness	( ) Tremors	
	( ) Trouble with memory/concentration		( ) Blackouts	( ) Seizures
Psychiatric	( ) Hallucinations	( ) Feeling Down	( ) Trouble Sleeping	
	( ) Suicidal Thoughts	( ) Inappropriate Crying/Laughing		
Hematologic/Lymphatic	( ) Abnormal Bleeding	( ) Anemia	( ) Lumps Swelling	
Allergic/Immunologic	( ) Rash	( ) Joint Pain	( ) Dry Eyes/Mouth	
Endocrinologic	( ) Excessive Thirst	( ) Heat/Cold Intolerance	( ) Excessive Urination	

Signature: Patient/Guardian ______________________ **Date:** __________