MEDICAL ASSOCIATES OF NORTH GEORGIA

Pain Clinic Director:
Steven M. Lobel, MD
Board Certified:
PM&R and Pain Medicine

Program Director:
Medical Associates
Pain Medicine Fellowship

Specializing in Interventional Spine and Sports Medicine

Name: **Date:** **Age:** **DOB:** **MR#** **Ref Physician:**

Chief Complaint:____When did it start?_____/_____/_____

HISTORY OF PRESENT ILLNESS: (circle all that apply)

Pain is: improving / worsening / stable / constant / intermittent
Pain is due to: car accident / work injury / sports injury / old age / disease / other
Is there a lawsuit or workers compensation claim? YES / NO

What worsens the pain? Standing / Sitting / Lying down / Walking / Twisting / Driving
Reaching / Change in weather / Cough / Sneeze / Leaning forward
Leaning backward / Other:

What reduces the pain? Standing / Sitting / Lying down / Walking / Twisting / Driving
Reaching / Heat / Cold / Leaning forward / Leaning backward / Other:

Is there new or different: weakness (not pain related)
loss of feeling
bowel/bladder incontinence (accidents)?

Reduced sleep: Yes / No Does your pain make you feel: depressed / angry / anxious

Prior therapies, injections, treatments: (circle all that apply) Physical Therapy / MRI / CT scan / EMG / Xray /
Discogram / Epidural / Other injection / Narcotics

Current Physicians:
PCP:_____________________ Surgeon:______________________
Other:____________________ Prior Pain Physicians: ___________

PAST MEDICAL HISTORY:

Diabetes	Heart disease	Blood pressure	Cancer	Stroke
Asthma	Emphysema	Liver disease	Kidney disease	Ulcers
Depression	Anxiety	Thyroid disease	Other:	

PAST SURGICAL HISTORY:

Appendix	Gall bladder	CABG/Angioplasty
Hysterectomy	Hernia repair	Tonsillectomy
Neck surgery	Back Surgery	Other surgery:

320 Hospital Road
Canton Georgia 30114
T: 770 479 5535 F: 770 479 8821
www.medassoc.com

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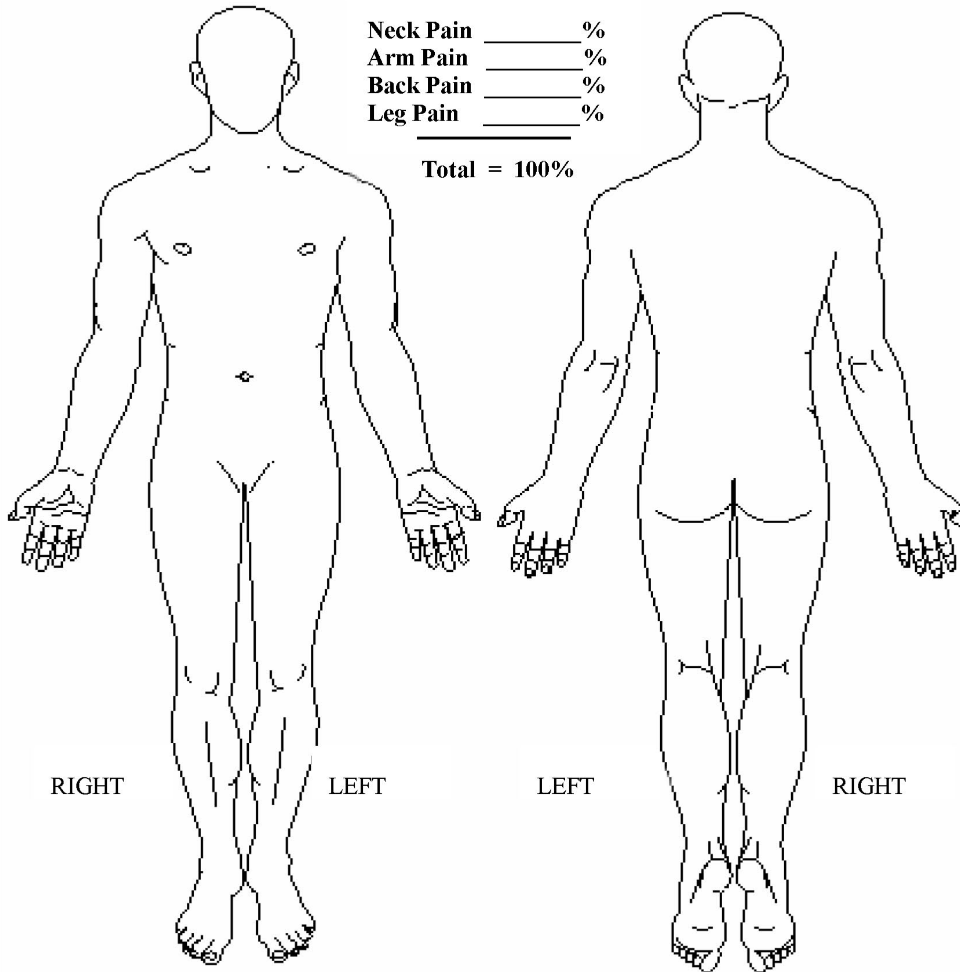
PATIENT: ______________________________ **AGE:**_________ **DATE:** ________________

WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol.

ACHE ^	NUMBNESS O	PINS & NEEDLES ■	BURNING X	STABBING +



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MEDICATIONS: ______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

PRIOR PAIN MEDICATIONS:____

OTC MEDICATION: Aspirin / Motrin / Advil / Aleve / Goody's / BC Powder / Other:

ALLERGIES: Drug: _________________ **Reaction** : _________________
_________________ _________________
_________________ _________________
_________________ _________________

SOCIAL HISTORY:

Married / Single / Divorced / Widowed Do you have children (how many)?_____
Alcohol use: None / Social / Daily (more than 2 drinks) Quit:
Tobacco: None or ___ packs per day x ___ years Quit:
Street Drugs:____________________________Current / Prior
Education: Grade school / HS / GED / Trade school / College / Post-grad
Occupation: Last worked:
Hobbies: Goals of treatment:

FAMILY HISTORY:

Genetic diseases / Neurological disease / Muscle disease / Stroke / Alcoholism or illegal substance abuse

REVIEW OF SYSTEMS: (*only circle if new complaint*)

Weight loss / Fever / Dizziness / Recent change in vision or double vision / Chest pain / Shortness of breath / Cough / Wheezing / Heartburn / Nausea / Vomiting / Diarrhea / Constipation / Bloody stools / Black stools / Blood in the urine / Rash / Easy bruising / New onset seizures / Recent memory loss / Hot or cold temperature intolerance / IV drug abuse / Suicidal thoughts / Sexual problems or decreased libido / Fatigue / Headache

Vital Signs: **Height =** **Weight=** **Temp =** **BP =** **HR =**