Central Arizona Pain Institute
Interventional Spine & Pain Management
2100 Centerpointe West Drive
Prescott, AZ 86301
Phone: 928.717.0788 www.centralazpain.com Fax: 928.717.0748

Patient's Medical History

Primary Care Provider: _____ **Office Number:** _____
Pharmacy (include city)**:**_____
Other Specialty Providers: _____
Cardiologist: _____
Spine surgeon: _____

Past Medical History: (please circle all that apply)

Anxiety	Asthma	Bipolar Disorder	Cancer (type: _____)
Congestive Heart Failure	Depression	Diabetes	Elevated Cholesterol
Emphysema	Fibromyalgia	GERD	Gout
Heart Disease	Hepatitis	HIV	Hypertension
Hyperthyroidism	Hypothyroidism	Kidney Disease	Lupus
Migraine Headache	Osteoarthritis	Osteoporosis	Peptic Ulcer Disease
Rheumatoid Arthritis	Sleep Apnea	Other: _____	

Past Surgical History: (please circle all that apply)

Appendectomy	Arthroscopy	Breast Augmentation	Caesarian Section
Carpal Tunnel Release	Cervical Fusion	Coronary Angioplasty	Coronary Artery Bypass
Gastric Bypass	Gall Bladder Removal	Hernia Repair	Hip Replacement
Hysterectomy	Knee Replacement	Laparoscopy	Lumbar Diskectomy
Lumbar Fusion	Rotator Cuff Repair	Tonsillectomy	Other: _____

Do you have any Implanted Devices (pacemaker, stimulator, etc.)? If so, please list the device, date implanted, and who manages them.

_____

_____

_____

Drug Allergies: (please circle all that apply)

Aspirin	Iodine	Latex	Morphine	Other: _____
NSAIDs	Penicillin	Shellfish	Sulfa	_____

Please describe your allergic reaction: _____

Allergies (continued):

Environmental Allergies: _____
Food Allergies: _____
Other Allergies: _____

Habits:

Do you vape, smoke or chew tobacco? Yes No
How many packs a day? _____ How many years? _____
If you have stopped, when did you stop? _____

Do you drink alcohol? Yes No
What do you drink? _____
How frequently? Rarely/ Occasionally/ Daily
How many drinks do you have? _____

Have you in the past or currently use illegal drugs? Yes No
What type? Amphetamines Cocaine Ecstasy
Heroin Marijuana Methamphetamines
Other: _____

Social History:

What is your marital status? Single Married Widowed Divorced
Do you have any children? Yes No How many? _____
What is your living situation? (please circle one)
Lives alone Lives with roommate(s) Lives with family

Family History:

□ Father/Mother deceased (circle one or both)

Does anyone in your immediate family have any medical illnesses? Yes No

Please circle all that apply and specify, **F** (Father), **M** (Mother), **S** (Sister), and/or **B** (Brother) next to diagnosis.

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Medications: Please include medications prescribed or supplements.

Name	Strength (mg)	Dose (how many times a day)	Date Last filled

My signature below signifies that the information that I have written above is true to the best of my knowledge.

Patient Name: _____ Signature: _____

Date: _____