FLORIDA PAIN MANAGEMENT ASSOCIATES

To help us meet all of your healthcare needs, please answer the following questions as completely as possible. Thank you.

PATIENT INFORMATION: **DATE:**___________________

NAME:________________________________ **SEX: M F** **AGE:**_________________

SSN:_____________________ **BIRTHDATE:**_____________ **MARITAL STATUS:**______

ADDRESS:_____________________**CITY/ STATE:**_______________ **ZIP CODE:**________

HOME #: _________________ **CELL #:** _________________ **WORK #:** _________________

E-MAIL ADDRESS: ____

PRIMARY CARE: __________________ **SOURCE OF REFERRAL:**___________________

ARE YOU PRESENTLY: EMPLOYED / RETIRED / DISABLED / UNEMPLOYED

WHAT WAS OR IS YOUR OCCUPATION? ___________________________________

IS THEIR A LAWYER INVOLVED WITH YOUR INJURY? ___________________
NAME OF LAWYER: ____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____________________________
PHONE #: ______________________________
RELATION: ___ __________________________
PHARMACY NAME: ______________________ **LOCATION:**________________
PHARMACY PHONE#:____________________

CIRCLE ONE: MEDICARE AUTO WORK COMP SELF-PAY OTHER
Please bring your insurance cards and a photo ID with you to your appointment

Primary Insurance: __________________ **Secondary Insurance:**___________________

***IF AUTO OR WORK COMP. PLEASE FILL OUT INFORMATION BELOW:**
Auto/ Work Comp Insurance:___________________________
Adjuster Name: _______________________________________
Phone #: _____________________________ **Ext.**____________
Billing Address: _______________________ **City:**_______________ **Zip Code:**___________
Claim #: _____________________________ **Date of Accident:** _______________________

I AUTHORIZE THE RELEASE OF NEEDED INFORMATION TO MY INSURANCE CARRIER, AND I AUTHORIZE PAYMENT OF MY INSURANCE BENEFITS TO FLORIDA PAIN MANAGEMENT ASSOCIATES.

________________________________ ___________________________
PATIENT SIGNATURE **DATE**

FLORIDA PAIN MANAGEMENT

Patient Name:______________________________ Date:________________

Height________________ Weight_______________

___ Yes ___ No **Problems with Anesthesia?**

___ Yes ___ No **Diabetes? Controlled with (circle): Insulin Pills Diet**

___ Yes ___ No **Heart Problems? Circle the one that applies:**
Heart attack (year)_________; Coronary heart disease;
Pacemaker/Defibrillator; Irregular heart beat; Palpitations;
Other___________

___ Yes ___ No **High Blood Pressure?**

___ Yes ___ No **Breathing Problems? (circle) On oxygen; Asthma; COPD;**
Emphysema; Chronic Cough; Sleep Apnea; Bronchitis;
Other____________

___ Yes ___ No **Smoker? _____ packs per day**

___ Yes ___ No **Stomach or Digestion problems? GERD/ Reflux**

___ Yes ___ No **Stroke: year of stroke______ Weakness-where__________**

___ Yes ___ No **Seizures? How often?___________________________**

___ Yes ___ No **Kidney/ Urinary Problems? Describe: ________________**

___ Yes ___ No **Liver/ Thyroid Problems? Describe:__________________**

___ Yes ___ No **Blood Thinners?(circle) Coumadin Warfrin Plavix Aspirin**
81mg 325mg Other________

___ Yes ___ No **Do you have Cancer? Where?_________ When?_______**
Undergoing treatment now?_________________________

___ Yes ___ No **Arthritis? ____**

___ Yes ___ No **Psychiatric Problems?_______________________________**

___ Yes ___ No **Substance Abuse?___________________________________**

___ Yes ___ No **Drink Alcohol? _____ drinks per day _____ per week**

Is there any other medical problem we should know about?

____
____
____

List Surgeries:

_____________________________ ____________________________
_____________________________ ____________________________
_____________________________ ____________________________
_____________________________ ____________________________

<u>ALLERGIES</u> to drugs, foods, dyes, preservatives: _____________ ___________
________________ ___________ _____________ ____________ ___________
_____________ ________________ ____________ ____________ ___________
____________ _____________ ______________ __________ ______________

List Prescription Medications Strength and Frequency:
____________________x day________ __________________x day__________
____________________x day________ __________________x day__________
____________________x day________ __________________x day__________
____________________x day________ __________________x day__________
____________________x day________ __________________x day__________
____________________x day________ __________________x day__________

List over the counter medicines (non-prescription, Vitamins-Aspirin etc)

______________________________ ____________________________
______________________________ ____________________________
______________________________ ____________________________

__________________________ ______________________
Patient Signature **Date**

FLORIDA PAIN MANAGEMENT ASSOCIATES

PLEASE CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR ANSWERS TO THE FOLLOWING STATEMENTS

WHEN YOUR PAIN IS AT ITS WORST

0 1 2 3 4 5 6 7 8 9 10
NO PAIN MILD DISCOMFORTING DISTRESSING HORRIBLE EXCRUCIATING

WHEN YOUR PAIN IS AT ITS LEAST

0 1 2 3 4 5 6 7 8 9 10
NO PAIN MILD DISCOMFORTING DISTRESSING HORRIBLE EXCRUCIATING

WHEN YOUR PAIN IS AT ITS AVERAGE

0 1 2 3 4 5 6 7 8 9 10
NO PAIN MILD DISCOMFORTING DISTRESSING HORRIBLE EXCRUCIATING

WHAT MAKES YOUR PAIN WORSE-(i.e. walking, standing, lifting)___________

WHAT MAKES YOUR PAIN BETTER-(i.e. heat, medicine, rest)?______________

WHAT TREATMENTS, MEDICATIONS, ETC. HAVE YOU TRIED TO RELIEVE YOUR PAIN? HAVE ANY OF THEM WORKED? _________________

REASON FOR YOUR CONSULTATION TODAY___________________________

FLORIDA PAIN MANAGEMENT

REQUEST FOR RELAEASE OF MEDICAL RECORDS

DR:____

ADDRESS:____

CITY:______________________ STATE: ________________ ZIP:__________

PHONE #:_________________________ FAX #: ___________________________

I hereby request the release of all medical, laboratory, radiology, operative and hospital records and reports to:

Dr. Harold J. Cordner, M.D.
Florida Pain Management
13825 US Hwy 1
Sebastian, FL 32958
(772) 388-9998 Fax (772) 388-9742

PATIENT NAME (PLEASE PRINT):_____________________________________

DATE OF BIRTH: ____________________

PATIENT SIGNATURE: ____

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