

# Pain Management Specialists

Jeffrey Benson, M.D., Ph.D.

## PAIN HISTORY QUESTIONNAIRE

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY / STATE / ZIP \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

AGE: \_\_\_\_\_ REFERRING DOCTOR: \_\_\_\_\_

PLEASE HAVE OUR OFFICE COPY YOUR INSURANCE CARDS.  
USING THE FIGURES TO YOUR RIGHT, SHADE IN THE AREAS WHERE YOU HAVE PAIN

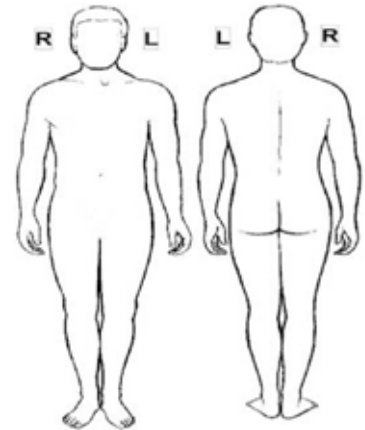
WHEN DID YOUR PAIN FIRST BEGIN? Month \_\_\_\_\_ Year \_\_\_\_\_

IS YOUR PAIN THE RESULT OF AN:

- Illness
- Accident
- Surgery
- Unknown cause

PLEASE CHECK ALL OF THE WORDS THAT DESCRIBE YOUR PAIN:

- ACHING
- THROBBING
- DULL
- SHARP/STABBING
- SHOOTING
- BURNING
- NUMBNESS
- TINGLING
- MUSCLE SPASM
- MUSCLE WEAKNESS



USING THE FOLLOWING PAIN SCALE (0 = NO PAIN, 10 = VERY SEVERE PAIN)

CIRCLE THE NUMBER THAT INDICATES YOUR PAIN

AT ITS BEST  
0 1 2 3 4 5 6 7 8 9 10

AT ITS WORST  
0 1 2 3 4 5 6 7 8 9 10

ON THE AVERAGE  
0 1 2 3 4 5 6 7 8 9 10

504 West Pueblo Street, Suite 301  
Santa Barbara, California 93105

P 805.682.5520  
F 805.682.1632

[www.painmanagementsb.com](http://www.painmanagementsb.com)

**IS YOUR PAIN INCREASED BY:**

- Coughing
- Straining
- Standing
- Walking
- Sitting
- Driving
- Touch
- Cold
- Other \_\_\_\_\_

**HAVE YOU HAD ANY OF THE FOLLOWING TESTS DONE?**

- X-Ray
- MRI
- CT-Scan
- Discogram
- Myelogram
- Nerve Conduction Studies
- EMG

**WHAT OTHER PAIN PROBLEMS HAVE YOU HAD IN THE PAST?**

- TMJ
- Back Pain
- Facial Pain
- Migraine Headaches
- Pelvic or Abdominal Pain
- Fibromyalgia

**IN THE PAST HAVE YOU HAD ANY OF THE FOLLOWING TREATMENTS FOR YOUR PAIN?**

- Nerve Blocks or Injections
- Facet Joint Blocks
- Epidural Steroid Blocks
- Physical Therapy
- Massage
- Acupuncture
- Chiropractic
- Tens
- Other

**ARE YOU NOW TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS WITHIN THE LAST THREE MONTHS?**

- Cortisone, Prednisone or Steroids
- Coumadin
- Lovenox
- Plavix
- Other blood thinners?

**ARE YOU SENSITIVE OR ALLERGIC (IE: RASH, SWELLING, ITCHY, TROUBLE BREATHING) TO ANY OF THE FOLLOWING:**

- Penicillin
- Sulfa
- Codeine
- Aspirin
- Motrin, Advil or Ibuprofen
- Novocain
- Sleeping Pills
- Other \_\_\_\_\_

**DO YOU HAVE ANY OF THE FOLLOWING HEALTH PROBLEMS?**

- Asthma
- Bronchitis
- Recent cold, flu, fever or infectious disease
- Heart problems
- Chest pain
- High blood pressure
- Hepatitis
- Diabetes

- Ulcers
- Gastritis
- Hiatal hernia or GERD
- Seizures
- Stroke

**DO YOU SMOKE?**

- Yes  No

**ARE YOU**

- Employed
- Retired
- Disabled

**ARE YOU**

- MARRIED
- SINGLE
- DIVORCED
- WIDOWED

**DO YOU LIVE**

- FAMILY
- ALONE
- OTHER

**HAVE YOU HAD ANY BACK SURGERY?**

Surgery	When	Where
1. _____		
2. _____		
3. _____		
4. _____		

**WHAT OTHER SURGERIES HAVE YOU HAD?**

Surgery	When	Where
1. _____		
2. _____		
3. _____		
4. _____		

**LIST ANY MEDICATIONS THAT YOU TAKE DAILY BELOW.**

Medication	Dose	Number of Pills per Day
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		