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ESTABLISHED 1947

INTERVENTIONAL PAIN MANAGEMENT

KEVIN T. TOLIVER, M.D.

**William L. Tontz, J.R., M.D.
PAIN HISTORY FORM**

Name: _____ Age: _____

Occupation: _____ Date: _____

1) What date (roughly at least) did your present pain start? _____

2) Mechanism of pain onset:

- | | | | |
|--------------|-----|----------------------|-----|
| a) Suddenly | { } | g) Pull | { } |
| b) Gradually | { } | h) Injured at work | { } |
| c) Lifting | { } | i) Auto accident | { } |
| d) Twisting | { } | j) Hit in back | { } |
| e) Fall | { } | k) Sports | { } |
| f) Bending | { } | l) No apparent cause | { } |

3) What activities make the pain worse?

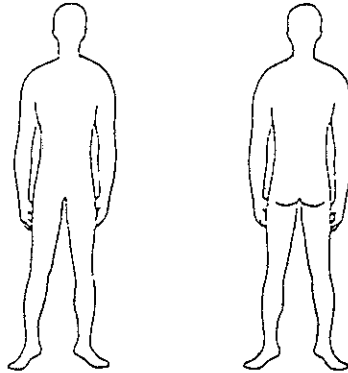
- | | | | |
|--------------------|-----|---------------------|-----|
| a) During exercise | { } | f) Bending forward | { } |
| b) After exercise | { } | g) Bending backward | { } |
| c) Sitting | { } | h) Coughing | { } |
| d) Standing | { } | i) Sneezing | { } |
| e) Walking | { } | | |

4) What reduces your pain?

- | | | | |
|---------------------|-----|---------------------|-----|
| a) Lying down | { } | g) Pain pills | { } |
| b) Sitting | { } | h) Muscle relaxants | { } |
| c) Standing | { } | i) Aspirin | { } |
| d) Walking | { } | j) Other _____ | { } |
| e) Physical therapy | { } | k) Nothing | { } |

5) How long have you had any neck/back pain?
 _____ Years _____ Months _____ Weeks
 How long have you had any arm/leg pain?
 _____ Years _____ Months _____ Weeks

6) Please mark on the diagram where your pain is located.



7) Does your pain interfere with sleep or awaken you at night?
 _____ yes _____ no

8) Have you had any x-rays? Yes _____ No _____
 Date: _____
 a) Have you had a CAT scan? Yes _____ No _____
 Date: _____
 b) Have you had a myelogram? Yes _____ No _____
 Date: _____
 c) Have you had an EMG? Yes _____ No _____
 Date: _____
 d) Have you had a discogram? Yes _____ No _____
 Date: _____
 e) Have you had an MRI scan? Yes _____ No _____
 Date: _____

9) Are you now unable to work because of pain?
 Yes _____ No _____

How long have you been off work?
 _____ Years _____ Months _____ Weeks

10) Have you been in the hospital for your back and neck problems?
 Yes _____ No _____ Number of times _____ Dates _____

Have you been in the hospital for your arm/leg problems?
Yes _____ No _____ Number of times _____ Dates _____

11) Have you had any neck or back surgery? Yes _____ No _____

12) Have you been in the hospital with other medical problems?
Yes _____ No _____ Number of times _____ Dates _____

13) Please list current medications (If none, please state) _____

14) General medical problems:

a) Stomach problems, Ulcers etc.	{ }	g) Cancer	{ }
b) Diabetes	{ }	h) Heart	{ }
c) Arthritis	{ }	i) Epilepsy	{ }
d) Gout	{ }	j) Other _____	{ }
e) Sexual difficulties	{ }	k) Weight loss	{ }
f) Bowel or bladder	{ }		

15) Medication Allergies: Yes _____ No _____
Please list _____

16) Do you smoke? Yes _____ No _____ How much? _____

17) Do you drink alcoholic beverages? Yes _____ No _____

18) What other types of doctors have you seen for this condition? _____

19) Do you have any additional information that would be helpful to understand your problem? _____

To be sure paperwork is filled out correctly, please check if appropriate:

On workers' compensation	{ }
Receiving disability income	{ }
Legal proceedings pending	{ }

Thank You.