

# NAPLES DAY SURGERY, LLC

## Comprehensive Pain Center of Naples

These questions are designed to help your pain Physician understand the nature of your pain, as well as which tests and treatments have been performed.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Male  Female Are you  Right-Handed  Left Handed

Referring Physician: \_\_\_\_\_ Last visit date: \_\_\_\_\_ Next visit date: \_\_\_\_\_

Family physician: \_\_\_\_\_

Other Physicians taking care of you: \_\_\_\_\_

**Allergies:** \_\_\_\_\_

Do you take any blood thinners?  Coumadin,  Lovenox,  Aspirin,  Plavix,  Ticlid,  Yes  No

Last dose taken when: \_\_\_\_\_

Do you have insurance to help pay for medications?  Yes  No

List all the medications (and dosages) you are presently taking:

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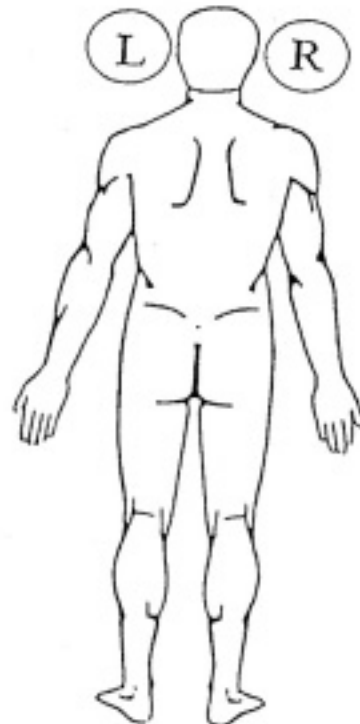
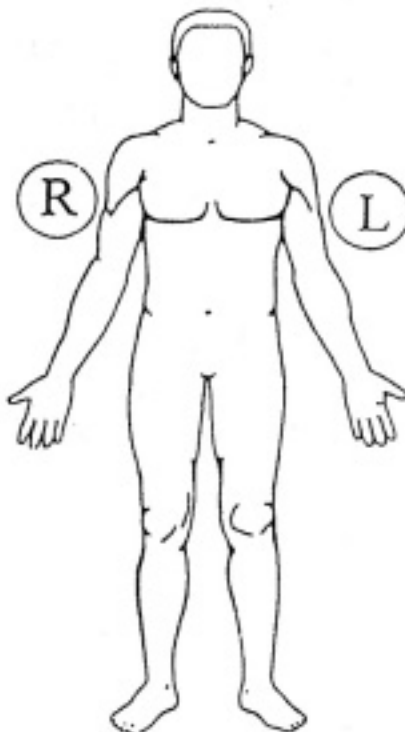
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### INFORMATION ABOUT YOUR PAIN:

A. Please color diagram: RED= PAIN

( If pain is more than one area please rank 1,2,3, etc.)

BLUE =NUMBNESS



Patient Label: \_\_\_\_\_

Room#: \_\_\_\_\_ Time In: \_\_\_\_\_

**PAST MEDICAL HISTORY** (Please Circle)

**CARDIAC**

Hypertension  
Heart Attack/MI  
Angina/Chest Pain  
CHF  
Pacemaker  
Arrhythmia

**GASTROINTESTINAL**

Hiatal Hernia  
Ulcers/Gastritis  
Pancreatitis  
GERD  
Irritable Bowel  
Diverticulitis

**IMMUNOLOGICAL**

Diabetes  
TB  
Cancer  
Thyroid  
Arthritis  
Colitis

**RESPIRATORY**

COPD  
Asthma  
Cough  
Chronic Bronchitis

**NEUROLOGICAL**

Headaches  
Seizures  
Stroke/TIA  
Head Injury

**OTHER**

Anemia  
Depression  
Fibromyalgia  
Osteoporosis

**NOT LISTED**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST SURGICAL HISTORY** (Please circle and state approximate year if known)

LUMBAR:	Laminectomy fusion	Hardware	Vertebroplasty/Kyphoplasty
CERVICAL:	Laminectomy fusion	Hardware	
ABDOMINAL:	Appendectomy	Gallbladder	Hysterectomy      Other _____
ORTHOPEDIC:	Knee(s)	Hips	Shoulder      Carpal Tunnel
HEAD/NECK:	Cataracts	Tonsils	

OTHER: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL INFORMATION**

Residence: Full Time \_\_\_\_\_ Seasonal \_\_\_\_\_ With whom do you live? \_\_\_\_\_

Education: Highest grade level you completed or college degree obtained: \_\_\_\_\_

Hobbies? \_\_\_\_\_

Recent Stress Events (Death, Divorce, Job Loss, etc.) \_\_\_\_\_

Occupation: \_\_\_\_\_

Are you receiving compensation or Disability?  No  Yes Medical or Psychological, Year: \_\_\_\_\_

Are you involved or considering LEGAL activity concerning your pain?  Yes  No

Briefly Explain: \_\_\_\_\_ Attorney: \_\_\_\_\_

Tobacco Use: Never Prior Smoker (Years \_ / Amount \_\_\_\_\_)  
Current Smoker (Years /Amount \_\_\_\_\_)

Alcohol Use:  None/1 Drink a Week  1 Drink a Day  3 Drinks per Day  6 or more a day  
 Recovered Alcoholic (Years \_\_\_\_\_)

Recreational Drugs:  No Yes, Prior Addictions \_\_\_\_\_

Psychiatric History: Do you have any of the following conditions treated by a Psychiatrist?  
 Depression  Anxiety  Schizophrenia  Bipolar  Phobias

Have you experienced any? (Please circle)

Weight Loss  
Loss of Appetite  
Loss of energy

Difficulty Sleeping  
Sad Moods  
Anxiousness

Fright or panic  
Nightmares  
Depression

Family Medical History (Please circle):

Arthritis	Cancer	Chronic Pain	Diabetes
Heart disease	Lung Disease	Liver Disease	TB
			Thyroid Disease

Patient Name/Label: \_\_\_\_\_

Patient ID Number: \_\_\_\_\_



**REVIEW OF SYSTEMS:** Are you *NOW* experiencing any of the following?

Chest Pain	Shortness of Breath	Nausea	Vomiting	Fever
Dry Cough	Productive Cough	Dizziness	Confusion	Constipation
Blurred Vision	Sedation	Itching	Rash	Hives
Wheezing	Swelling	Diarrhea	Incontinence	Weight Loss
Hearing Loss	Night Sweats	Spasms	Difficulty in Sleeping	

Obviously you desire total pain relief: **IF** that is **NOT POSSIBLE** what would you consider successful therapy?

**NOTES:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<b>TIME OUT INFO:</b>	
TIME OUT:	_____, RN
CORRECT: PATIENT:	_____ C
PROCEDURE/POSITION:	_____
SIGNED CONSENT:	_____
IMPLANTS/EQUIPMENT:	_____

**PRE-PROCEDURE:**

**Vital Signs:** BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ T \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_

\_\_\_\_\_

**PROCEDURE**

Diagnosis \_\_\_\_\_ Procedure Start: \_\_\_\_\_

Procedure: \_\_\_\_\_ Procedure End: \_\_\_\_\_

\_\_\_\_\_

**POST PROCEDURE**

<b>Vital Signs:</b>	Time			
_____		P _____	R _____	B/P _____
_____		P _____	R _____	B/P _____
_____		P _____	R _____	B/P _____
_____		P _____	R _____	B/P _____

**DISCHARGE CRITERIA:**

	YES NO		YES NO
1. Vital Signs stable	<input type="checkbox"/> <input type="checkbox"/>	5. Paresthesia	<input type="checkbox"/> <input type="checkbox"/>
2. Bleeding Absent	<input type="checkbox"/> <input type="checkbox"/>	6. Increase in Pain	<input type="checkbox"/> <input type="checkbox"/>
3. Ambulates with preprocedural gait	<input type="checkbox"/> <input type="checkbox"/>	7. Post procedure pain rating 0-10 _____	
4. LOC consistent with preprocedure status	<input type="checkbox"/> <input type="checkbox"/>	8. Verbalizes understanding regarding treatment plan	<input type="checkbox"/> <input type="checkbox"/>

Time of discharge: \_\_\_\_\_

**NURSES SIGNATURE:** \_\_\_\_\_

Patient Name/Label: \_\_\_\_\_

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

Patient ID Number: \_\_\_\_\_