Medical history (check all that apply):

❑ Heart attack
❑ Heart failure
❑ Angina (chest pain)
❑ High blood pressure
❑ Stroke
❑ Diabetes
❑ High cholesterol
❑ Phlebitis
❑ Glaucoma
❑ Rheumatic fever
❑ Heart condition
❑ Cancer of_____

❑ Rheumatoid arthritis
❑ Osteoporosis
❑ Pneumonia
❑ Asthma
❑ Bronchitis
❑ Emphysema
❑ Blood vessel disease
❑ Sciatica
❑ Vascular disease
❑ Headache
❑ Hearing/ear disorder

❑ Mental illness
❑ Gout
❑ Ankylosing spondylitis
❑ Kidney stones
❑ Kidney failure
❑ Transplants
❑ Alcohol dependence
❑ Alzheimer's
❑ Nerve disorder
❑ Anemia
❑ Hepatitis
❑ Other_____

❑ Blood clots in legs
❑ Stomach ulcers
❑ Bleeding disorders
❑ Sickle cell disease
❑ Epilepsy
❑ Arthritis
❑ Kidney disease
❑ Osteoporosis
❑ Thyroid problem
❑ Liver trouble

Number of Items_____ Patient initials_____

Social History

Married? ❑ yes ❑ no Children? ❑ yes ❑ no Number of children:_____
Mother Alive? ❑ yes ❑ no Healthy? ❑ yes ❑ no
Father Alive? ❑ yes ❑ no Healthy? ❑ yes ❑ no
Brother(s) Alive? ❑ yes ❑ no Healthy ❑ yes ❑ no Number of brothers:_____
Sister(s) Alive? ❑ yes ❑ no Healthy ❑ yes ❑ no Number of sisters:_____

Work Status Occupation: _____
❑ Working ❑ Not working ❑ Retired ❑ Disabled
❑ Veteran ❑ Homemaker ❑ Student

Alcohol use
❑ Never ❑ Rare ❑ Frequent Drinks per week_____
❑ Alcohol dependent ❑ Recovered alcoholic

Drug use
❑ Never ❑ Past ❑ Currently

Tobacco use (check all that apply)
❑ Never ❑ Cigarettes I have smoked _____ packs of cigarettes per day for _____ years total
(If less than one pack per day) I have smoked _____ cigarettes per day for _____ years total
❑ Cigars I have smoked _____ cigars per day for _____ years total
❑ I quit smoking on (date) _____

Family History (check all that apply) ❑ None apply

Condition	Which family member(s)?	Condition	Which family member(s)?
❑ Heart disease		❑ Scoliosis	
❑ Stroke		❑ Spine problems	
❑ High blood pressure		❑ Bleeding disorders	
❑ Diabetes		❑ Cancer	
❑ Osteoporosis		❑ Other (list)	
❑ Rheumatoid arthritis		❑ Other (list)	
❑ Osteoarthritis		❑ Other (list)	

My signature confirms that the answers to the above questions are accurate to the best of my ability.

_____ Date: _____

Patient/Guardian (if under 18) signature:

_____ Date: _____

New Patient Questionnaire

UNIVERSAL PAIN MANAGEMENT INSTITUTE

DONALD E. ROLAND M.D.
555 West Court St., Suite 100
Kankakee, Illinois 60901

555 West Court Street • Suite 100 • Kankakee, Illinois 60901 • Ph. (815) 932-7242 • Fax (815) 932-7307

Name_____ Date _____
Address _____ Phone _____
Social Security Number_____ Date of Birth _____
Age _____ Height_____ Weight _____
Primary Physician (Name & Address)_____
Referring Doctor (Name & Address)_____

History of Present Illness

What is your main health concern? _____
How many physicians have your seen regarding your pain problem? _____

1	2	3	4	5	6	7	8	9	10
No Pain		Slight		Moderate		Severe			Extreme

Would you describe your pain as: ❑ burning? ❑ yes ❑ no ❑ sharp? ❑ yes ❑ no
❑ aching? ❑ yes ❑ no ❑ throbbing? ❑ yes ❑ no
❑ shooting? ❑ yes ❑ no
❑ other (describe) _____

Does your pain travel to other parts of your body? ❑ yes ❑ no
If yes, where? _____

Which statement best describes your pain?
❑ Always present, always the same intensity, ❑ Always present, intensity varies, ❑ Usually present, but have short periods without pain, ❑ Often present, but have pain free periods lasting for one to several hours, ❑ Occasionally present for brief periods, a few seconds to a few minutes, ❑ Rarely present, have pain every few days or weeks

What time of day is your pain worst?
❑ Morning on arising
❑ Later in the morning
❑ Afternoon
❑ Evening
❑ Bedtime
❑ Night (during usual sleeping hours)
❑ Pain is always the same
❑ Pain varies, but is not worse at any particular time

Do you have:
Numbness? ❑ yes ❑ no
Tingling, pins and needles? ❑ yes ❑ no
Weakness? ❑ yes ❑ no
Skin discoloration? ❑ yes ❑ no
Coldness? ❑ yes ❑ no
Increased sweating? ❑ yes ❑ no
Muscle spasm, tightness? ❑ yes ❑ no
Bowel or bladder problems? ❑ yes ❑ no

Does pain interrupt your sleep? ❑ yes ❑ no

When you are feeling pain, do any of the following items help decrease your pain? (Check all that apply)
❑ lying down ❑ tens unit ❑ cool compress ❑ massage ❑ watching TV
❑ sitting ❑ alcohol ❑ medication ❑ getting away ❑ nothing
❑ standing ❑ work ❑ socializing ❑ changing position
❑ walking ❑ activity ❑ heating pad ❑ warm bath

Check those items that increase your pain:
❑ physical activity ❑ sitting ❑ standing ❑ lying down ❑ walking
❑ loud noises ❑ damp weather ❑ warm weather ❑ financial worries ❑ massage
❑ stress ❑ anger ❑ other people ❑ cold weather ❑ coughing, sneezing