

Space Coast Pain Institute
Richard E. Gayles, M.D. Stanley Golovac, M.D.

Name: _____ **Date:** _____

Height: _____ **Weight:** _____ **Referring M.D. :** _____ **Primary M.D.:** _____

Reason for visit (location of pain, date of onset, precipitating event, treatments tried, etc.) _____

Current Medications (including dose/frequency/reason for med): _____ **or** _____ **NONE**

Pharmacy _____

Surgical History (include all surgeries – not just those related to this visit): _____ **or** _____ **NONE**

Allergies: _____ **or** _____ **NONE**

Medical History (Please circle all that apply to you): _____ **or** _____ **NONE**

Cancer: (list site)	Cardiac:	Endocrine:	Gastrointestinal:	Genitourinary:	Hematology:	Musculoskeletal:
_____	Atrial fibrillation	Diabetes	Constipation	Dialysis	Anemia	Arthritis – Osteo
_____	Cong. Heart Failure	Hyperthyroidism	Cirrhosis	Incontinence	Blood Clots	Arthritis – Rheum
_____	Heart Attack	Hypothyroidism	Diarrhea	Kidney Stones		Deg Disc Disease
_____	High Cholesterol	Insulin/oral meds	Diverticulosis	Prostate		Fibromyalgia
	Hypertension		GERD	Retention		Osteoarthritis
	Mit. Valve Prolapse		Hepatitis A B C	Urgency		Osteoporosis
	Murmur		Hernia			Spinal Stenosis
	Pacemaker		IBS			
	Stents		Ulcers			
	Stroke					
	Tachycardia					
	TIA					

Neurologic:	Psychological:	Respiratory:	Vision:	Other:
Headaches	Anxiety	Asthma	Cataracts R L	
Mul Sclerosis	Bipolar	Bronchitis	Mac. Degen.	
Neuropathy	Depression	COPD	Glaucoma	
	Post traumatic stress	Cough		
	Schizophrenia	Emphysema		
	Sleep Disorders	Tuberculosis		

Significant Family History (blood relatives only): _____

Social History: Marital Status: _____ Occupation: _____ Retired or Disabled? _____

Living Arrangements: Alone With Spouse With Significant Other Other: _____

Alcohol Use: Rare Socially Daily Never

Tobacco Use: Cigarettes Cigars Pipes Other: _____ PPD _____ Yrs: _____ Quit date: _____

Assistive Devices Used: Hearing Aid Cane Wheelchair Walker Other: _____

WORK STATUS: _____ Regular Duty _____ Light Duty, Restrictions: _____

_____ Off Work: Last worked: _____

_____ Disabled: Since: _____ By what Doctor: _____

_____ Retired: Since what year: _____

Location of pain: _____

What treatments have you had for your pain? Check all that apply:

_____ Physical Therapy _____ Favorable Results _____ Poor Results

_____ Acupuncture _____ Favorable Results _____ Poor Results

_____ Chiropractor _____ Favorable Results _____ Poor Results

_____ Trigger Point Injection _____ Favorable Results _____ Poor Results

_____ TENS Unit _____ Favorable Results _____ Poor Results

_____ Nerve Blocks _____ Favorable Results _____ Poor Results

Type of Nerve Block _____

_____ Back or Neck Surgery Type: _____ When: _____

_____ Spinal Cord Stimulator Type: _____ Date Implanted: _____

_____ Morphine Pump Type: _____ Date Implanted: _____

_____ Other: _____

PATIENT SIGNATURE:

DATE: