OMEGA PAIN MANAGEMENT

Initial Medical History Questionnaire

Your Name: _____ DOB _____/_____/_____

PCP:_____ Referring MD:_____

CHIEF COMPLAINT:

1) Where is your pain? (neck, lower back, etc.) _____

Please describe how your pain began: ~ date/ year of onset, what caused it and events until now.

_____

_____

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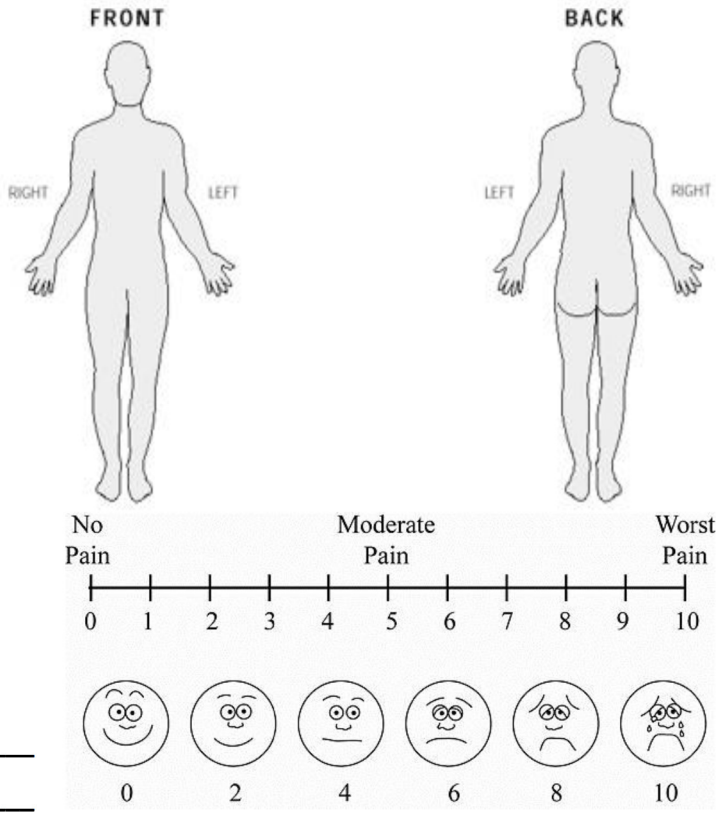
Please indicate, on the diagram below, the location of your pain



2) Describe the pain: ❑ Throbbing ❑ Shooting ❑ Sharp ❑ Dull ❑ Aching ❑ Tingling ❑ Burning

3) What number on the pain scale (0-10) describes your WORST pain? _____

4) What number on the pain scale (0-10) describes your CURRENT pain? _____

5) Have you tried Physical Therapy? if yes: when was the last time and did it help you?_____

PREVIOUSLY TRIED MEDICATIONS:

	Helped?		Never taken		Helped?		Never taken		Helped?		Never taken
Opiates	**Y**	**N**		**NSAID**	**Y**	**N**		**Muscle Relaxant**	**Y**	**N**	
Vicodin (Hydrocodone)				Motrin (Ibuprofen)				Flexeril (Cyclobenzaprine)			
Percocet (Oxycodone)				Aleve (Naproxen)				Baclofen			
OxyContin				Relafen (Nabumetone)				Robaxin (Methocarbamol)			
Morphine ER MS Contin				Mobic (Meloxicam)				Zanaflex (Tizanidine)			
Oxymorphone/ Opana ER				Celebrex				Norflex			
Hydromorphone/ Exalgo ER				Diclofenac (Voltaren)				Skelaxin (Metaxolone)			
Fentanyl/ Duragesic patch				Etodolac				Parafon Forte			
Butrans patches				Tylenol				Soma			
Suboxone				**OTHER**							
Methadone				Gabapentin/ Neurontin							
Ultram/Tramadol				Lyrica							
Nucynta				Cymbalta							
				Savella							
				Lidoderm patches							
				Fioricet							

REVIEW OF SYSTEMS:

Do you currently have any of these symptoms? (Please circle all that apply)

General: fever, chills, night sweats, anorexia, fatigue, weight loss, weight gain
Eyes: pain, redness, blurred vision, loss of vision
Ears/Nose/Throat: ear pain, ringing in ears, hearing loss, sore throat, hoarseness
Cardiovascular: chest pain, irregular heartbeat, shortness of breath, syncope/fainting
Respiratory: cough, wheezing, excessive mucous
Gastrointestinal: nausea, vomiting, diarrhea, constipation, abdominal pain, bloody stools, indigestion.
Genitourinary: painful urination, blood in urine, urinary frequency, incontinence, decreased sex drive
Musculoskeletal: joint pain, joint swelling, muscle cramps, muscle aches, muscle weakness
Skin: rash, itching, dry skin
Neurologic: weakness, seizures, tremors, vertigo, headaches, tingling, numbness, visual disturbance
Psychiatric: sleep problems, mood swings, depressed mood, confusion, anxiety/panic attacks.
Endocrine: heat intolerance, cold intolerance, excessive thirst, excessive urination, constipation, diarrhea, dry skin, tremor, changing menstrual patterns
Heme/ Lymphatic: bleeding, easy bruising, leg swelling (edema)

PAST MEDICAL HISTORY: (please circle)

❑ Alcoholism
❑ Anemia
❑ Anxiety
❑ Arthritis
❑ Asthma
❑ Atrial fibrillation
❑ Cardiac pacemaker
❑ Congestive heart failure
❑ COPD
❑ Coronary Artery Disease
❑ Depression
❑ Diabetes
❑ DVT-blood clots
❑ Fibromyalgia
❑ GI bleeding
❑ Glaucoma
❑ Headache
❑ Hearing loss
❑ Heart attack
❑ Heartburn - GERD
❑ Hepatitis B
❑ Hepatitis C
❑ High blood pressure
❑ High cholesterol
❑ HIV-AIDS
❑ Hyperthyroidism
❑ Hypothyroidism
❑ Irritable Bowel Syndrome
❑ Kidney failure- Dialysis
❑ Kidney stones
❑ Liver cirrhosis
❑ Multiple sclerosis
❑ Osteoporosis
❑ Pancreatitis
❑ Polyneuropathy
❑ RSD / CRPS
❑ Schizophrenia
❑ Seizures
❑ Stomach ulcer
❑ Stroke
❑ Tuberculosis
❑ Urinary tract infection

Blood clots/ Pulmonary (lung) Embolism? (if yes, date and are you on COUMADIN?)_____

ADDITIONAL MEDICAL HISTORY: _____

_____

PAST SURGICAL HISTORY:

❑ Appendectomy ❑ Cardiac bypass ❑ Cardiac pacemaker ❑ Cardiac stents ❑ Cesarean section ❑ Gall bladder

❑ Hysterectomy ❑ Kidney stones surgery ❑ Thyroidectomy ❑ Tonsillectomy

Please list any additional surgeries, side, surgeon's name and ~ date**:** (i.e. Rt total knee replacement, Dr. Smith 2009)

1_____ 4_____

2_____ 5_____

3_____ 6_____

FAMILY HISTORY:

	Stroke	**Cancer/type**	**Arthritis**	**Heart prob**	**Diabetes**	**High BP**	**Other**
Mother							
Father							

SOCIAL HISTORY:

Cigarette Smoking Y N Packs per day: _____

Alcohol Y N How many alcoholic drinks per week?_____

History of drug abuse: Y N What type of drug?_____ Last used_____

CURRENT MEDICATION LIST:

Medication Name	**Dose**	**Frequency**	**Medication Name**	**Dose**	**Frequency**

Are you taking any blood thinners? Please circle: Coumadin/ Warfarin Plavix Effient Xarelto Pradaxa

ALLERGIES (both to medications and non-medications/ **any IV Dye allergy?**):

_____

_____

Mark all of the following studies you have had in the last 3 yrs that are related to your current pain complaints:

MRI of the: _____ Date: _____ Facility: _____

X Rays of the: _____ Date: _____ Facility: _____

CT scan of the: _____ Date: _____ Facility: _____

******* AFTER YOU FINISH THE FIRST 4 PAGES PLEASE GIVE THEM TO THE SECRETARY BEFORE COMPLETING THE REST OF THE FORMS. THIS WAY WE CAN START ENTERING YOUR INFORMATION AND TAKE YOU TO THE ROOM FASTER**********

NEW PATIENT REGISTRATION FORM

OMEGA PAIN MANAGEMENT

********ATTN: You DO NOT have repeat the same information – just write "SAME" or "N/A" where appropriate********

Patient Name: _____ Social Security #:_____

Date of Birth: _____/_____/_____ Age: ____Sex: M / F Status: Married / Single / Divorced / Widowed

Address: _____

Home/Work/Cell #: _____ Home/Work/Cell #: _____

Primary Policy Holder's Name:		**Secondary** Policy Holder's Name:	
Insurance Co Name:	Prim. Policy Holder's DOB:	Insurance Co Name:	Prim. Policy Holder's DOB:
Prim. Policy Holder's Cell	Prim. Policy Holder's SSN:	Prim. Policy Holder's Cell	Prim. Policy Holder's SSN:
Policy #:	Group #:	Policy #:	Group #:
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other		Relationship to Patient (circle one): ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other	

WORKER'S COMPENSATION – Is this a work related injury? ☐ Yes ☐ No
MOTOR VEHICLE ACCIDENT – Is this a motor vehicle accident injury? ☐ Yes ☐ No
CHARGES CANNOT BE BILLED TO YOUR HEALTH INSURANCE CARRIER.
IF WORKER"S COMPENSATION OR MVA INFORMATION IS NOT PROVIDED, YOU WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED

WORKER'S COMP, AUTO & PIP COVERAGE
Workers Comp Company:_____ W/C Adjuster's Name: _____
Phone #:_____ Fax #:_____
Claim#:_____ Date of Injury: _____/_____/_____

AUTO PIP: Claim#:_____ Date of Accident: _____/_____/_____
Case Manager: _____ Phone & Fax_____
PIP: Attorney's Name: _____ Phone & Fax_____
Attorney's Address: _____

Patient Signature:_____ Date: _____

PATIENT AUTHORIZATION for USE

and DISCLOSURE of PROTECTED HEALTH INFORMATION (HIPPA)

Omega Pain Management takes your privacy seriously. We will not disclose your medical records (protected health information) to any party without your signed consent, except as stipulated in our Notice of Privacy Practices. This form authorizes Omega Pain Management to release your medical records to parties indicated.

Emergency Medical Information Contacts

Name_____ Home/Work/Cell #: _____ Relationship_____

Name_____ Home/Work/Cell #: _____ Relationship_____

I understand that the above people, their phone numbers and answering machines/voicemails **WILL** be used to leave potentially sensitive medical information and will possibly be used to leave messages concerning pill counts, drug screen results and other information concerning my medical treatment management.

Assignment of Benefits Agreement

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to Omega Pain Management for medical or surgical services or items rendered to me or my dependent by Omega Pain Management. Should my insurance carrier deny Omega Pain Management payment, I understand that I am financially responsible for the charges. I authorize Omega Pain Management to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. It is my responsibility to update any and all personal, insurance and health information.

I acknowledge that I have had the opportunity to review Omega Pain Management's Notice of Privacy Practices, which is displayed on its website www.omegapaindoctor.com or by asking for a copy from our staff. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I certify that the above information (page 1 of the New Registration Form) is accurate, complete and true. I give my consent for Omega Pain Management to retrieve and review my medication history. I understand that this will become part of my medical record. I understand that I am responsible for the entire cost of my treatment regardless of insurance coverage or payments. I hereby authorize the release of any medical information to process any insurance claims. I further understand that if it ever becomes necessary for this account to be turned over for collections, I am responsible for any collection and/or attorney fees. I authorize the release of any information needed to process my insurance claims. I hereby authorize and acknowledge that any scanned signature is considered an original signature

Patient Signature:_____ Date: _____

OMEGA PAIN MANAGEMENT

9217 Park West Blvd, Ste E-1
Knoxville, TN 37923
Ph; (865) 337-5137

AGREEMENT FOR OPIOID MAINTENANCE THERAPY FOR NON-CANCER/CANCER PAIN

The purpose of this agreement is to prevent misunderstandings about certain medicines that you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I, _____Date of birth:_____ Phone:_____

understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship, and that my doctor undertakes to treat me based on this agreement. I understand that I am agreeing to the following:

1. I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain in my daily life, and how well the medicine is helping to relieve my pain.
2. I will not use any illegal controlled substances, including marijuana, cocaine, etc.
3. I will not share, sell, or trade my medication with anyone.
4. I will not attempt to obtain any controlled medicines, including opioid pain medicines from any other doctor.
5. I will safeguard my pain medicine from loss or theft. Lost or stolen medicine will NOT be replaced.
6. I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during the evenings or on weekends.
7. I understand that a written prescription is required on controlled medications. I also understand that my doctor will not call in refills to pharmacies for these medications.
8. I agree that I will submit to a random blood or urine test, or random pill count if requested by my doctor to determine my compliance with my program of pain control medicine. I agree that I will arrive with my medicines within two (2) hours of being called for a random pill count and/or blood/urine test.
9. I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
10. I agree to bring all bottles, with unused medicine to every visit. I agree to still bring the bottle even if empty. No bottles means no refills.
11. I agree to use the below listed pharmacy, and no other pharmacy for all my pain control medicine needs.
12. I agree to notify the office if I will be out of town for more than 24 hours.

I agree to use_____Pharmacy, located in_____

Telephone number_____, for filling prescriptions for all my pain medicine.

I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the authorizations.

I agree to follow this guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

Date_____ Patient's Signature _____Witness's Signature_____