

PPM Pennsylvania Pain Management

MEDICAL & FAMILY HEALTH HISTORY

All information provided will be kept **CONFIDENTIAL**.

Name	Date of Birth	DATE
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Have you had or do you currently have	YES	NO	Please list any treatment you had or are currently receiving	Family members who had or currently have these disorders
Frequent Headaches				
Migraines				
Sleep Disorders				
Depression				
Ulcers				
Diabetes				
Lung Disease				
High Blood Pressure				
Heart Disease				
Cancer				
Vascular Disease				
Thyroid				
Bladder/Urinary				
Muscle Pain/Weakness				
Back Pain				
Kidney Disease/Problems				
Liver Disease/Problems				
Drug or Alcohol Abuse				
Asthma				
Shortness of Breath				
Fainting				
Dizziness				

	YES	NO	
Do you smoke cigarettes?			Packs per day
Do you drink Alcohol? How much?			<input type="checkbox"/> Every Day # <input type="checkbox"/> Once a Week # <input type="checkbox"/> Socially #
Do you feel you get a good nights' sleep?			Approx # of hours per night :
Have you been tested for HIV?			Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Have you been tested for Hepatitis?			Results: Type B <input type="checkbox"/> Positive <input type="checkbox"/> Negative Type C <input type="checkbox"/> Positive <input type="checkbox"/> Negative