New Jersey
HEALTHCARE SPECIALISTS
PRINCETON PAIN MANAGEMENT
AN Envision Physician Services AFFILIATED PROVIDER

NEW PATIENT DEMOGRAPHIC INFORMATION

NAME: _____

ADDRESS: _____

Phone Number(s): Home#_____ Cell#_____

E-Mail Address: _____

Emergency Contact: Name: _____ Relationship: _____

Telephone: _____

Referring Physician: Name: _____

Address: _____

Phone#: _____ Fax#:_____

Primary Care Physician: Name: _____

Address: _____

Phone#: _____ Fax#: _____

Insurance: Primary Insurance: _____

Insured Name: _____ ID# _____

Provider services Phone# _____

Secondary Insurance: _____

Insured Name: _____ ID# _____

Provider Services Phone# _____

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SYSTEM REVIEW & PAST MEDICAL HISTORY

Name: _____ Date of birth: _____

From the following list, please check any symptoms or conditions that apply to you.

Skin	Heart & Circulation	Kidneys/urinary tract
[ ] rashes, psoriasis, dermatitis	[ ] heart attack	[ ] kidney disease or failure
[ ] history of skin cancer	[ ] high blood pressure	[ ] history of kidney dialysis
[ ] New skin growth or mole	[ ] heart murmur	[ ] kidney stones or infection
Eyes	[ ] chest discomfort (angina)	[ ] pain or burning with urination
[ ] wear glasses	with physical activity	[ ] trouble starting urine stream
[ ] wear contact lenses	[ ] heart failure or fluid on lungs	[ ] dribble or incontinence
[ ] permanent blindness	[ ] palpitations/racing or	[ ] multiple trips to the bathroom to
[ ] cataracts	pounding heartbeat	urinate at night
[ ] glaucoma	[ ] stroke	[ ] bladder infections during past year
Ears/Nose/Throat	[ ] blood clot in artery or vein	[ ] blood in urine during the past yr.
[ ] loss of hearing	[ ] Mini strokes or TIA's	[ ] prostate disease
[ ] hearing aids [ ] yes [ ] no	[ ] black out spells	**Muscles/Joints/Bones**
[ ] ringing in ears	[ ] aneurysm	[ ] Arthritis or other joint disease
[ ] frequent earaches	[ ] frequent ankle swelling	[ ] chronic back trouble
[ ] discharge from ear	bedtime	[ ] bone or joint surgery in past yr.
[ ] attacks of vertigo	[ ] heart surgery	**Nervous system**
[ ] frequent sinus infection	**Stomach/Intestines**	[ ] migraine headaches
[ ] nasal blockage	[ ] stomach ulcer or peptic ulcer	[ ] Epilepsy or seizures
[ ] frequent sneezing	[ ] heartburn/indigestion	Date of last seizure
[ ] frequent sore throat	[ ] hiatal hernia or acid reflux	[ ] Depression
[ ] loud snoring	[ ] poor appetite	[ ] Other nervous disorder
[ ] change in voice quality	[ ] gall bladder attacks	Specify:
[ ] sleep apnea	[ ] frequent diarrhea	**Blood**
[ ] difficulty swallowing	[ ] chronic constipation	[ ] bleeding or bruising tendency
[ ] frequent headaches	[ ] bright blood from bowel	[ ] previous blood transfusion
[ ] nose bleeds	[ ] dark tarry stools	[ ] history of hepatitis
[ ] exposure to loud noises	[ ] liver disease or jaundice	
Respiratory	**Endocrine/Metabolism**	**Reproductive (women only)**
[ ] Asthma or wheezing	[ ] Thyroid disease	Are you or might you be pregnant?
[ ] bronchitis/chest cold	[ ] recent weight gain or loss	[ ] Yes [ ] No
[ ] cough for over past 2months	(more than 10 lbs.)	
[ ] coughing up blood	[ ] Diabetes	
[ ] shortness of breath		

Please circle the following diseases if your family members (blood relatives have experienced them:

Diabetes Cancer High blood pressure Allergy Hearing Loss Stroke Bleeding disorder

List any other illness that runs in your family: _____

Signature: _____ Date: _____

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Annual MIPS Questionnaire General

Patient Name: _____ Date: _____

1. Do you have little or no interest in doing things?

   _____ NO _____YES

   If yes, please check one: _____Several Days _____More than half the days _____Everyday

2. Are you feeling down depressed or hopeless?

   _____ NO _____YES

   If yes, please check one: _____Several Days _____More than half the days _____Everyday

If you answered YES to question 1 or 2, then complete the following table. If you answered NO to both questions 1 and 2, then you DO NOT have to complete the table, skip to below.

	Not at all (0)	**Several days** (1)	**More than half the days** (2)	**Everyday** (3)
3. Do you have trouble falling or staying asleep or sleeping too much?				
4. Do you feel tired or have little energy?				
5. Do you have poor appetite or overeating?				
6. Do you feel bad about yourself, feel like a failure, or feel you have let yourself or your family down?				
7. Do you have trouble concentrating on things, such as reading the newspaper or watching television?				
8. Do you move or speak to slowly that other people could have noticed? Ore the opposite? Are you fidgety or restless and move around more than usual?				
9. Do you have thoughts that you would be better off dead and/ or have thoughts of hurting yourself in some way?				

Have you fallen in the last 365 days? (Answer only if 65 years and older)

_____ No _____ Yes: _____ 1 fall with injury _____ 2 or more falls with injury

_____ 1 fall without injury _____ 2 or more falls without injury

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OPIOID RISK TOOL (2018 Edition)

Name: _____ Date _____

Family history of substance abuse

Check only those boxes that apply

Family history alcohol abuse?	[ ] YES	[ ] NO
Family history illegal drugs abuse?	[ ] YES	[ ] NO
Family history prescription drugs abuse?	[ ] YES	[ ] NO

Personal history of Substance abuse

Check only those boxes that apply

Personal history alcohol abuse?	[ ] YES	[ ] NO
Personal history illegal drugs abuse?	[ ] YES	[ ] NO
Personal history prescription drugs abuse?	[ ] YES	[ ] NO
Age between 16-45 years?	[ ] YES	[ ] NO
History of Preadolescent sexual abuse?	[ ] YES	[ ] NO

Psychologic Disease

Check only those boxes that apply

ADD, OCD, Bipolar, Schizophrenia?	[ ] YES	[ ] NO
Depression?	[ ] YES	[ ] NO

ALCOHOL MISUSE/ABUSE (AUDIT C)

Name: _____ **DOB** _____

Did you have a drink containing alcohol in the past year?

- ☐ Yes
- ☐ No

If 'Yes' : How often did you have a drink containing alcohol in the past year?

- ☐ Never (0 point)
- ☐ Monthly or less (1 point)
- ☐ 2 to 4 times a month (2 points)
- ☐ 2 to 3 times a week (3 points)
- ☐ 4 or more times a week (4 points)

If 'Yes' : How many drinks did you have on a typical day when you were drinking in the past year?

- ☐ 1 or 2 drinks (0 point)
- ☐ 3 or 4 drinks (1 point)
- ☐ 5 or 6 drinks (2 points)
- ☐ 7 to 9 drinks (3 points)
- ☐ 10 or more drinks (4 points)

If 'Yes' : How often did you have 6 or more drinks on one occasion in the past year?

- ☐ Never (0 point)
- ☐ Less than monthly (1 point)
- ☐ Monthly (2 points)
- ☐ Weekly (3 points)
- ☐ Daily or almost daily (4 points)

Points ☐

Interpretation

- ☐ Positive
- ☐ Negative

Interpretation

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use).

- In men, a score of 4 or more is considered positive.
- In women, a score of 3 or more is considered positive.

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Princeton Pain Management: Update of Medication List **Pt. Name** _____

Allergies: _____

Pharmacy: _____ **Height:** _____ **Weight:** _____

In medication column, list name(s) of ALL medication, strength, route (pills, patches, inhalers, etc.)

Medication	Dose	Frequency	Last Dose Taken	Reason for Taking Medication