S. Vengurlekar, M.D., P.C.
Premier Pain Institute
Center for Minimally Invasive Interventions of Complex Spinal Pain
Telephone (480) 314-2288 FAX (480) 314-1113

PLEASE PRINT AND COMPLETE THE FOLLOWING INFORMATION - ALL BLANKS MUST BE COMPLETED

Last Name	First Name	Middle Initial	Today's Date
			/ /

Date of Birth	Age	Sex	Name of Spouse (Name of parent or guardian, if a minor)
/ /		M / F	

Arizona Address	City	Zip	Marital Status
			S M W D Sep

Permanent Address (If different from above)	City	Zip	Permanent Phone Number
			( ) -

Home Phone Number	Cell Phone Number:	Social Security Number
( ) -	( ) -	- -

Name of Employer	Work Phone Number	Occupation
	( ) -	

Spouse/Other Insurers Information Name	Address (If different than above)	
Phone Number	Date of Birth	Social Security Number

EMERGENCY CONTACT:	Phone number:

Name of Referring Physician	Address	Phone Number:
		Fax Number:

Name of Primary Care Physician (If different from Referring Physician)	Address	Phone Number:
		Fax Number:

Name of Primary Insurance Company	Name of Secondary Insurance Company

I UNDERSTAND I AM RESPONSIBLE FOR NOTIFYING THE OFFICE OF SHAM M. VENGURLEKAR, M.D. OF ANY CHANGES IN THE ABOVE INFORMATION.

Patient/Responsible Party Signature _____ Date _____

PREMIER
PAIN
INSTITUTE

S. VENGURLEKAR, MD., PC
Diagnosis and Minimally Invasive Therapies
for Spinal, Extremity, Head and Neck Pain.
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OFFICE USE ONLY

Height _____ **Weight**_____ **Blood Pressure**_____ **Temp** _____ **Pulse** _____ **RR** _____

Patient's Name: _____ Date of Birth: _____

Referring Physician: _____ Today's date: _____

Dear Patient;

I place a lot of emphasis on the details of your symptoms of pain and other aspects of your medical history. This form will help me in arriving at an accurate diagnosis and formulating the appropriate interventional pain therapies tailored to your needs.

Please pay close attention to the following items, which you need to fill out completely and accurately.

ESTABLISHED PATIENT CONSULTATION

1.) Date of onset of pain_____ 2.) Location of primary pain _____
3.) Nature of pain _____ (e.g., sharp, stabbing, stinging, etc.)
4.) Continuous or Intermittent? _____
5.) Did you have a fall, injury, accident prior to the onset of pain? No [ ] Yes [ ]
If yes, what date? _____Briefly describe:_____

6.) Intensity of pain:
No pain 0 1 2 3 4 5 6 7 8 9 10 **Severe pain**

7.) Activities that increase your pain:
Sitting ___ Walking ___ Standing ___ Coughing/Sneezing ___
Bending ___ Sports activities ___ Lying down___

8.) List activity that relieves your pain (excluding medications):
Sitting ___ Lying down ___ Ice/Heat ___ Other _____

9.) Sleep pattern: Unchanged? [ ] Interference with sleep? [ ]
a) How many hours of sleep do you get _____

10.) Ability to pursue activities/occupation _____

11.) **Current Medication**: *(list **ALL** pain medications & dosages)*

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

12.) List **ALL** medications that you have taken in the **past** to control your pain and mark in the ( ) what type of relief you received: e.g. **(R)** relief **(SR)** some relief **(NR)** No relief

_____( ) _____( ) _____( ) _____( )
_____( ) _____( ) _____( ) _____( )

13.) List any medications you are taking for **other** medical disorders (also include herbal/supplements/over the counter medications):

_____ _____ _____ _____
_____ _____ _____ _____

14.) List any drug, food or environmental allergies and type of reaction: (e.g.: penicillin, sulfa, itching, rash)

_____

_____

PATIENT'S INITIALS _____

ESTABLISHED PATIENT CONSULTATION **PATIENT'S NAME**_____

15.) **Other Treatment**: Please write in the ( ) whether your symptoms were:
(**W**) Worsened (**I**) Improved (**U**) Unchanged

Chiropractic	( )	**Acupuncture**	( )
Massage	( )	**Epidural Blocks**	( )
Trigger point inj.	( )		
Physical Therapy	( )		

If you have had therapy, when did you go? _____
How many sessions did you have? _____

16.) TESTS PERFORMED FOR **CURRENT CONDITION** BY ANOTHER PHYSICIAN/FACILITY

X-rays	( )	**CT Scans**	( )
MRI Scans	( )	**EMG/nerve conduction studies**	( )
Labs	( )	**Other**	( )

17.) LIST ANY **NEW** MEDICAL CONDITIONS AND/OR SURGICAL HISTORY **WITHIN THE LAST SIX MONTHS** *(list **all** medical problems, e.g.: Asthma, High Blood Pressure, Heart disorders, Cardiac workup, Appendectomy, Hernia surgery, Hysterectomy, Breast implants, .)*

_____
_____
_____

18.) System Review: *(Circle all that apply)*

a) **Cardiac**: chest pain/heart attack/high blood pressure/irregular heart beat/heart murmur/shortness of breath
b) **Lungs**: cough/blood in sputum/asthma/bronchitis/valley fever/ tuberculosis
c) **ENT**: nasal discharge/obstruction/nasal bleeding/hearing loss/vertigo/hoarseness of voice.
d) **Neurological**: headaches/seizures/stroke/paralysis/dizziness/ ringing in ears
e) **Skeletomuscular**: fibromyalgia/arthritis/lupus/connective tissue disorder
f) **Skin/Integumentary**: rash/pigmentation spots/moles
g) **Hormonal**: thyroid/sex hormones
h) **Metabolic**: diabetes/elevated cholesterol/elevated triglycerides
i) **Blood Disorder**: increased bleeding/thalassemia/hemophilia/ Christmas disease/sickle cell disorder/phlebitis or clots in leg or lung
j) **Urinary:** burning/lack of continence/increased frequency/kidney stone/ blood in urine/prostate problems/impotence
i) **Stomach/bowel:** ulcer/acidity/constipation/diverticulitis/diarrhea/blood in stool

19.) Past or current exposure to:
a) Tuberculosis [ ] b) Valley fever (cocci) [ ] c) Rheumatic fever [ ] d) Hepatitis (jaundice) [ ] e) AIDS. [ ] f) Other _____

20.) **HABITS - PLEASE NOTE ANY CHANGES** (if no change please put N/C).

1.) SMOKING: YES/NO

2.) ALCOHOL: YES/NO If yes, how much _____
3.) DRUGS:
a.) Use of any street or recreational drugs _____
b) Use of **prescription** drugs for recreation use _____

21.) **FAMILY HISTORY** – LIST ANY MEDICAL CONDITIONS AND THE FAMILY MEMBER(S) APPLICABLE: *(e.g.: cardiac history, stroke, diabetes, asthma, infectious diseases, cancer, etc.)*

_____
_____

PATIENT'S INITIALS _____