SA PAIN CLINIC

Phone: 210-298-4900 Fax: 210-298-6631

Larina V. Gutenberg, D.O.
Roberto J. Diaz, M.D.
Adam Fish, D.O.
Ma Luo, M.D.

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

Patient Name: _____ DOB: _____

How do the following factors affect your pain?

	Better	Worse	No effect		Better	Worse	No effect
Heat	☐	☐	☐	Climate	☐	☐	☐
Cold	☐	☐	☐	Fatigue	☐	☐	☐
Lying down	☐	☐	☐	Coughing	☐	☐	☐
Sitting	☐	☐	☐	Massage	☐	☐	☐
Walking	☐	☐	☐	Alcohol	☐	☐	☐
Sneezing	☐	☐	☐	Lifting	☐	☐	☐
Sleeping on back	☐	☐	☐	Sleeping on stomach	☐	☐	☐
Sex	☐	☐	☐				

Which of the following activities are affected by your pain?

☐ Mood ☐ Activities of daily living ☐ Social interactions ☐ Household chores ☐ Sexual Activity
☐ Work ☐ Falling asleep ☐ Staying asleep ☐ Leisure ☐ Ability to enjoy life

Do you have any: ☐ Urinary incontinence ☐ Stool incontinence ☐ Sexual dysfunction

Check the treatments you have had for pain, please provide treatment dates:

☐ Acupuncture: _____ ☐ Physical Therapy: _____
☐ Biofeedback: _____ ☐ Exercise: _____
☐ Psychotherapy: _____ ☐ TENS unit: _____
☐ Facet Blocks: _____ ☐ Epidurals: _____
☐ Nerve Blocks: _____ ☐ Trigger Points: _____
☐ Massage: _____ ☐ Hypnosis: _____
☐ Chiropractor: _____ ☐ Brace: _____
☐ Surgery: _____ ☐ Spinal Cord Stimulator: _____
☐ Intrathecal Pump: _____ ☐ Botox: _____
☐ Radiofrequency: _____ ☐ Light therapy: _____
☐ Traction devices: _____ ☐ Pain Management? If so, Dr. _____
☐ Prior Use of Opioids for pain? Yes >>No ☐ Outcome of opioid therapy? _____

PAST MEDICAL HISTORY

Musculoskeletal

☐ Arthritis ☐ Fibromyalgia ☐ Muscle Spasms
☐ Numbness ☐ Weakness

Neurological

☐ Headache ☐ Seizures
☐ Stroke ☐ Migraines

REVIEW OF SYSTEMS

Constitutional

☐ Chills ☐ Fever ☐ Fatigue
☐ Obesity ☐ Weight loss ☐ Weight gain
☐ Night Sweats ☐ Loss of appetite

☐ Confusion ☐ Dizziness ☐ Light Sensitivity
☐ Chewing ☐ Sense of Smell ☐ Swallowing
☐ Loss of balance ☐ Memory Loss ☐ Change in facial
☐ Change in voice/speech/appearance

SA PAIN CLINIC

Phone: 210-298-4900 Fax: 210-298-6631

Larina V. Gutenberg, D.O.
Roberto J. Diaz, M.D.
Adam Fish, D.O.
Ma Luo, M.D.

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

Patient Name: _____ DOB: _____

PAST MEDICAL HISTORY **REVIEW OF SYSTEMS**

Psychiatric

☐ Depression ☐ Substance abuse ☐ Suicidal thoughts ☐ Fatigue
☐ Anxiety ☐ Bipolar ☐ Schizophrenia ☐ Difficulty Sleeping ☐ Mood Swings

Cardiovascular

☐ Angina ☐ Heart Attack ☐ Heart Stent ☐ Chest Pain ☐ Palpitations
☐ Pacemaker ☐ Hypertension
☐ Valve issues that require pre-procedure antibiotic prophylaxis

Respiratory

☐ Asthma ☐ Emphysema ☐ Chronic Bronchitis ☐ Cough ☐ Shortness of Breath ☐ Bloody Cough
☐ Any hospitalizations for respiratory problems

Gastrointestinal

☐ Reflux ☐ Hepatitis ☐ Ulcers ☐ Diarrhea ☐ Constipation ☐ Abdominal Pain
☐ Incontinence ☐ Cirrhosis ☐ Colon Cancer ☐ Heartburn ☐ Bloating ☐ Painful BM
☐ Diverticulitis ☐ GI bleeding ☐ IBS ☐ Vomiting ☐ Bloody Stools ☐ Nausea
☐ Inflammatory bowel disease ☐ Portal hypertension ☐ Hepatic encephalopathy

Genitourinary

☐ Impotence ☐ Kidney Stones ☐ Incontinence ☐ Decreased Libido ☐ Urinary frequency
☐ Cancer ☐ Kidney Disease ☐ UTI ☐ Prostate Problems ☐ Urinary Hesitancy
☐ Bloody Urine ☐ Hemodialysis, days Hemodialysis is done _____

Integumentary

☐ Herpes Zoster/Shingles ☐ Skin Cancer ☐ Rash/Hives ☐ Itchy Skin ☐ Swelling

Endocrine, Hematologic, Allergy/Immunologic

☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Easy Bruising ☐ Ringing in Ears
☐ HIV ☐ Lymphoma ☐ Leukemia ☐ Visual Changes
☐ Multiple Myeloma ☐ Adrenal Issues ☐ Pituitary issues ☐ Low platelets
☐ Von Willebrand disease ☐ Cancer: _____
☐ Problems with blood clotting immunodeficiencies ☐ Any recent immunosuppressive therapies?

PAST MEDICAL HISTORY **REVIEW OF SYSTEMS**

Rheumatologic

☐ Lupus ☐ Sjogren's ☐ Scleroderma ☐ Painful joints ☐ Blurry Vision ☐ Polymyalgia Rheumatic
☐ Rheumatoid Arthritis ☐ Multiple Sclerosis ☐ Other: _____

Sleep Behavior

Have you ever been evaluated for sleep apnea with a sleep study? ☐Yes ☐ NO
Were you diagnosed with sleep apnea? ☐ Yes ☐ NO
If yes, are you currently using a CPAP machine or Bi-PAP machine? ☐ Yes ☐ NO

SA PAIN CLINIC

Phone: 210-298-4900 Fax: 210-298-6631

Larina V. Gutenberg, D.O.
Roberto J. Diaz, M.D.
Adam Fish, D.O.
Ma Luo, M.D.

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

Patient Name: _____ DOB: _____

Implantable devices: Please, let us know if you have any of the following:

☐ Pacemaker ☐ Defibrillator ☐ Deep Brain Stimulator ☐ Peripheral Nerve Stimulator
☐ Bladder Stimulator ☐ Insulin Pump ☐ Spinal Cord Stimulator
☐ Intrathecal Pumps: medication in the pump_____ date pump was refilled: _____

Do you have ALLERGIES to any medications? ☐ YES ☐ NO If yes, please list: _____

SOCIAL HISTORY

Do you smoke? ☐ YES ☐NO How many packs per day?_____ How many years? _____
Do you drink alcohol? ☐ YES ☐NO How much per day?_____ How many years?_____
Do you have a history of drug use, addiction, or abuse? ☐ YES ☐ NO If yes, explain: _____
Have you ever been treated for addiction or alcoholism? ☐ YES ☐ NO If yes, explain: _____
Have you ever had an issue with prescription medications (misuse, abuse, addiction, etc.)? ☐ YES ☐ NO
If yes, explain: _____

Marital Status

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced with Family

Living situation

☐ Alone ☐ Spouse ☐ Friend ☐ Long Term/Assisted Living Facility

Employment Status

☐ Currently Employed ☐ Full time ☐ Part time ☐ Never If currently working what type of work: _____
If in the past: ☐ Retired ☐ Disabled ☐ Unemployed

Safety: Do you feel safe in your home or place of residence? YES NO

PAST SURGICAL HISTORY (mark and/or list surgeries that you have had and provide approximate date):

☐ Appendectomy: _____ ☐ Tonsillectomy/Adenoids: _____ ☐ Gallbladder surgery:_____
☐ Coronary Bypass: _____ ☐ Hernia Repair: _____ ☐ Hemorrhoid: _____
☐ Tubal Ligation: _____ ☐ Mastectomy: _____ ☐ Breast Biopsy: _____
☐ Prostate: _____ ☐ Vasectomy: _____ ☐ Hysterectomy and ovaries: _____
☐ Knee Replacement: _____ ☐ Hip Replacement: _____ ☐ Knee Surgery: _____
☐ Shoulder Surgery: _____ ☐ Cataracts: _____ ☐ Colon: _____
☐ Back Surgery: _____ ☐ Neck Surgery: _____ ☐ Other: _____

WOMEN: ARE YOU PREGNANT? ☐YES ☐NO ☐NOT SURE PATIENT'S INITIALS: _____

FAMILY HISTORY

	DIABETES	HEART	ANXIETY	KIDNEY	CANCER	DEPRESSION	BACK	OTHER CONDITIONS
MOTHER	☐	☐	☐	☐	☐	☐	☐	☐_____
FATHER	☐	☐	☐	☐	☐	☐	☐	☐_____
BROTHER(S)	☐	☐	☐	☐	☐	☐	☐	☐_____
SISTER(S)	☐	☐	☐	☐	☐	☐	☐	☐_____

SA PAIN CLINIC

Phone: 210-298-4900 Fax: 210-298-6631

Larina V. Gutenberg, D.O.
Roberto J. Diaz, M.D.
Adam Fish, D.O.
Ma Luo, M.D.

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

Patient Name: _____ DOB: _____

List All Medications You Are Currently Taking:

Medication	Dose	Medication	Dose
1.		**9.**	
2.		**10.**	
3.		**11.**	
4.		**12.**	
5.		**13.**	
6.		**14.**	
7.		**15.**	
8.		**16.**	

If not stated before, primary care doctor name _____ and

address_____

I ACKNOWLEDGE THAT I HAVE COMPLETED THIS QUESTIONNAIRE ACCURATELY AND TO THE BEST OF MY KNOWLEDGE.

_____ _____

Signature of Patient, Parent or Guardian Date