10 Timberview Lane, Russell PA 16345
1095 Million Dollar Highway, St. Marys PA 15857
Dr. Timothy W. Vollmer DO DABA
Phone: (814) 593-1215
Fax: (814) 253-5843

PATIENT HISTORY QUESTIONNAIRE

Please review and complete this Medical Questionnaire and bring it with you to your first appointment. This information is confidential. If you are unable to print it out and bring it with you prior to your first appointment, please present to the office 30 minutes prior to your first appointment to fill out this information.

Name:_____ Date of Birth:_____ Age:_____

Referring Physician:_____ Phone #:_____

Primary Care Provider:_____ Phone #:_____

Pharmacy Information:_____ Phone #:_____

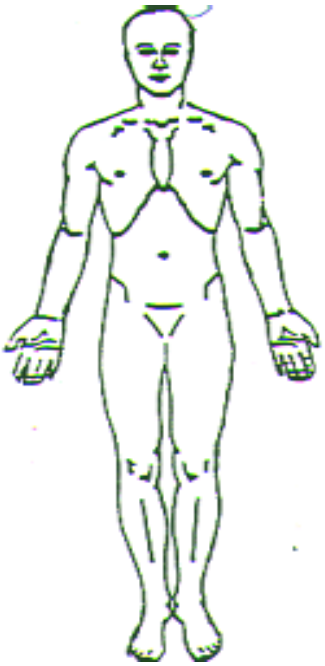
Pharmacy Fax #:_____

PAIN

Circle the area where you have pain, put an "X" over the area that hurts the most:

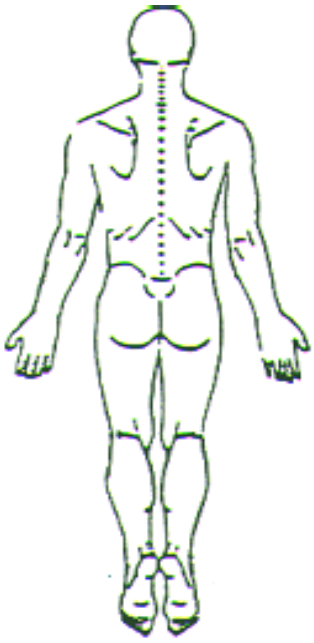
Front

Right **Left**



Back

Left **Right**



Briefly describe your main pain complaint:

_____

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How did your pain begin?			
Accident at work	Date:	Other:	Date:
Following Surgery	Date:	If other, explain:	
Pain just Began	Date:		
Auto Accident	Date:		
Following an Illness	Date:		

Describe your Pain:			
☐ Sharp	☐ Squeezing	☐ Aching	Other:
☐ Shooting	☐ Hot	☐ Splitting	
☐ Stabbing	☐ Burning	☐ Cold	
☐ Throbbing	☐ Piercing	☐ Dull	
☐ Cramping	☐ Tingling	☐ Numb	
☐ Stinging	☐ Tender	☐ Gnawing	

Please rate your pain 1-10 with 10 being most severe: _____

How often do you have your pain? (circle) Constant Most of the Time Occasionally Rarely

When is your pain worse? (circle) Morning Afternoon Evening Bedtime

What makes your pain *Worse*:			
☐ Sitting	☐ Exercise	☐ Alcohol	Other:
☐ Standing	☐ Bright lights	☐ Meals	
☐ Walking	☐ Heat	☐ Menstruation	
☐ Bending/Twisting	☐ Stress	☐ Poor Sleep	
☐ Lifting	☐ Cold	☐ Weather Changes	
☐ Lying	☐ Inactivity	☐ Loud Noise	

What makes your pain *Better*:			
☐ Cold	☐ Warm Shower	☐ Heat	Other:
☐ Exercise	☐ Relaxation	☐ Distraction	
☐ Activity	☐ Prayer	☐ Medication	

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Are there any other symptoms associated with your *Pain*?			
☐ Numbness	☐ Bowel Incontinence	☐ Night Time Movement	Other:
☐ Weakness	☐ Urinary Incontinence	☐ Anger	
☐ Tenderness	☐ Fatigue	☐ Sexual Dysfunction	
☐ Vomiting	☐ Swelling	☐ Nausea	
☐ Redness	☐ Blurred Vision	☐ Sleep Apnea	

TREATMENTS

Please check any of the following treatments that you have tried to treat your pain:			
☐ Acupuncture	☐ Traction	☐ Pain Clinic	Other:
☐ Biofeedback	☐ Exercise	☐ Hypnosis	
☐ Bedrest	☐ Physical Therapy	☐ Psychotherapy	
☐ Chiropractor	☐ TENS	☐ Injection Therapy	

MEDICATIONS

Please check (√) ALL Current and Past medications you have taken for your current pain condition:

ANALGESICS	**NSAIDS**	**ANTIDEPRESSANTS**
☐ Acetaminophen/Tylenol	☐ Celecoxib/CELEBREX	☐ Amitriptyline/ELAVIL
☐ Fentanyl/DURAGESIC	☐ Choline Magnesium	☐ Bupropion/WELLBUTRIN
☐ Hydrocodone/VICODIN	☐ Salicylate/TRILSAIE	☐ Citalopram/CELEXA
☐ Hydromorphone/DILAUDID	☐ Diclofenac/VOLTAREN	☐ Duloxetine/CYMBALTA
☐ Meperidine/DEMEROL	☐ Diflunisal/DOLOBID	☐ Escitalopram/LEXAPRO
☐ Methadone/DOLPHINE	☐ Etodolac/LODINE	☐ Fluoxetine/PROZAC
☐ Morphine/MS CONTIN, KADIAN, AVINZA	☐ Flurbiprofen/ANSAID	☐ Nortriptyline/PAMLOR
☐ Oxycodone/OXYCONTIN,PERCOCET, TYLOX	☐ Ibuprofen/MOTRIN	☐ Paroxetine/PAXIL
☐ Propoxyphene/DARVOCET	☐ Indomethacin/INDOCIN	☐ Sertraline/ZOLOFT
☐ Tramadol/ULTRACET/ULTRAM	☐ Ketoprofen/ ORUDIS	☐ Venlafaxine/EFFEXOR
☐ Tylenol with codeine #2, #3, #4	☐ Ketorolac/TORADOL	☐ Quetiapine fumarate/ SEROQUEL
	☐ Meloxicam/MOBIC	
	☐ Nabumetone/RELAFEN	
	☐ Naproxen/NAPROSYN	
	☐ Oxaprozin/DAPRO	
	☐ Piroxicam/FELDENE	
	☐ Tolmetin/TOLECTIN	

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ANXIOLYTICS/SEDATIVES	MUSCLE RELAXANTS	ANTICONVULSANTS
☐ Alprazolam/XANAX	☐ Baclofen/LIORESAL	☐ Topiramate/TOPAMAX
☐ Buspirone/BUSPAR	☐ Carisoprodol/SOMA	☐ Gabapentin/NEURONTIN
☐ Diazepam/VALIUM	☐ Cyclobenzaprine/FLEXERIL	☐ Levetiracetam/KEPPRA
☐ Eszopiclone/LUNESTA	☐ Metaxalone/SKELAXIN	☐ Pregabalin/LYRICA
☐ Flurazepam/DALMANE	☐ Methocarbamol/ROBAXIN	
☐ Haloperidol/HALDOL	☐ Tizanidine/ZANAFLEX	
☐ Hydroxyzine/ATARAX		
☐ Lorazepam/ATIVAN		
☐ Ramelteon/ROZEREM		
☐ Temazepam/RESTORIL		
☐ Triazolam/HALCION		
☐ Zaleplon/SONATA		
☐ Zolpidem/AMBIEN		

OTHER MEDICATIONS TRIED FOR CURRENT PAIN:

Please list ALL medications that you are CURRENTLY taking. (Include medications for pain, heart, diabetes, blood pressure, blood thinners, as well as over the counter medications and herbal products, etc.) You can also attach a list if needed.

Medications	Dosage	Directions	Ordering Physician	Date Started

Are you allergic to any medications or foods?

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Medication/Agent			When	Type of Reaction
Latex	☐ YES	☐ NO		
Penicillin	☐ YES	☐ NO		
Sulfa	☐ YES	☐ NO		
IV Dye	☐ YES	☐ NO		
Shellfish	☐ YES	☐ NO		
Medication Allergies (please list):				

MEDICAL HISTORY

Do you have any of the following? Please check (√) ALL that apply.			
☐ High Blood Pressure	☐ Heart Attack	☐ Asthma	☐ Stomach Ulcer
☐ Kidney Disease	☐ Seizure	☐ Depression	☐ Arthritis
☐ Diabetes	☐ Stroke	☐ Hepatitis	☐ Cancer
☐ Thyroid Disease	☐ Liver Disease	☐ Lung Disease	☐ Fibromyalgia
☐ Pacemaker	☐ HIV	☐ A-Fib	☐ Peripheral Neuropathy
☐ GERD	☐ Bowel Disease	☐ Migraines	☐ On Blood Thinners
☐ Low Blood Sugar	☐ Dialysis	☐ Glaucoma	
Other:			

MENTAL HEALTH HISTORY

Have you ever had mental health treatment?	☐ YES	☐ NO	If yes - Date:
Are you in current mental health treatment? (Psychiatrist, Psychologist, Counselor)	☐ YES	☐ NO	If yes - Provider's Name:
Have you ever been hospitalized for psychiatric reasons?	☐ YES	☐ NO	If yes - Date:
If yes, give general reason for hospitalization:			

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SURGICAL HISTORY

Have you ever had any type of surgery? Please list below.		
Procedure:	Date:	Surgeon:
Procedure:	Date:	Surgeon:
Procedure:	Date:	Surgeon:
Procedure:	Date:	Surgeon:
Procedure:	Date:	Surgeon:
Procedure:	Date:	Surgeon:
Procedure:	Date:	Surgeon:
Procedure:	Date:	Surgeon:
Procedure:	Date:	Surgeon:

SOCIAL HISTORY

Marital Status: (circle) Single Married Divorced Separated Widowed How long?:
Are you pregnant or planning to become pregnant? (circle) N/A NO YES Due Date:

If you have any children, please list:			
Name	**Age**	**Grade**	**Areas of Concern**

Do you smoke tobacco? (circle)	YES NO FORMER	Type used:
Packs per day?	Years smoked:	Year Quit:
Do you use oral tobacco? (circle)	YES NO FORMER	Years Used: Year Quit:
Do you drink alcohol? (circle)	YES NO FORMER	Year Quit:
Type:	Amount Daily:	Last drink:
Do you use drugs? (circle)	YES NO PAST USAGE	Type Used:
Do you use drugs not prescribed to you? (circle)	YES NO PAST USAGE	Medication Name:

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Currently employed? (circle)	YES NO RETIRED	Type of Work:
Are you disabled? (circle)	YES NO CURRENTLY APPLYING	Disability Date: Disability Reason/Diagnosis:
Have you ever applied for disability and been not approved? (circle)	YES NO	If yes, when: Disability Diagnosis:

FAMILY MEDICAL HISTORY

Please check (√) if any family member has had any of the following conditions and indicate the family member.

☐ Adopted	MOTHER	FATHER	SISTER	BROTHER	OTHER
Cancer Type	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Angina	☐	☐	☐	☐	☐
Congenital Heart Disease	☐	☐	☐	☐	☐
Congestive Heart Failure	☐	☐	☐	☐	☐
Coronary Heart Disease	☐	☐	☐	☐	☐
Heart Failure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐	☐
Chronic Renal Impairment	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Kidney Stone	☐	☐	☐	☐	☐
Renal Failure Syndrome	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐
Respiratory Disease	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Mental Disorder	☐	☐	☐	☐	☐
Psychotic Illness	☐	☐	☐	☐	☐

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Substance Abuse	☐	☐	☐	☐	☐
Abdominal Aortic Aneurysm	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

REVIEW OF SYMPTOMS (ROS)

System	**Symptom (circle)**
General	Fever, Chills, Night Sweats, Unintentional Weight Loss, Fatigue, Malaise
Eyes	Visual Changes, Double Vision, Blurry Vision, Headache, Eye Pain
ENT	Runny Nose, Nose Bleeds, Sinus Pain, Tinnitus, Sore Throat, Painful Swallowing
Cardiovascular	Chest Pain, Irregular Heart Rate, Exercise Intolerance, Leg Swelling
Pulmonary	Persistent Cough, Bloody Cough, Sputum, Wheeze, Shortness of Breath
GI	Abdominal Pain, Constipation, Vomiting, Diarrhea, Bloating, Bloody Stools
Musculoskeletal	Joint Pain, Muscle Pain, Stiffness, Decreased Range of Motion, Crepitus
Integumentary	Rashes, Skin Lesions, Itchy Skin, Excessive Dryness
Neurologic	Sensory Changes, Seizures, Headaches, Poor Balance, Speech Problems
Psych	Depression, Anxiety, Paranoia, Mania, Personality Changes
Hematologic	Anemia, Easy Bleeding, Easy Bruising, Hemophilia, Anticoagulant Use

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PATIENT FINANCIAL RESPONSIBILITY POLICY

- Always bring your insurance card and ID to your appointment. If your coverage cannot be verified, you will be responsible for any payments at the time of service.

- It is your responsibility to notify us if there are any changes to your insurance, address, phone number, or family status at check-in or sooner.

- It is your responsibility to pay for your co-pay, co-insurance, and/or deductible at the time of service.

- If uninsured, it is your responsibility to pay your bill in full at the time of service.

- If your insurance does not cover any office visit, diagnostic testing, and/or treatment, you understand that you are responsible for payment of service and will make immediate, satisfactory arrangements to settle your account.

- Collection Fees: In the event that your account is referred to a third-party collection agency, you agree that you will be responsible for any and all collection fees.

- Litigation Fees and Costs: In the event that your account is referred to a third-party collection agency and/or collection attorney, you agree that you will be responsible for any and all collection/attorney fees and interest. If costs are expended in order to collect your account, you understand that you will be responsible for the costs. These costs could include court costs for filing suit against you.

- Telephone Consumer Protection Act Consent Disclosure: In order for us to service your account or to collect any amounts you may owe us, you authorize us and our affiliated physicians/ medical providers, as well as their affiliates which include debt collectors, to contact you at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact include but are not limited to the use of pre-recorded voicemail messages, artificial voicemail messages, automatic telephone dialing systems, predictive telephone dialing systems, automated SMS text message reminders, and facsimile as applicable.

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If you have:	You are responsible for:	Our staff will:
Commercial Insurance also known as indemnity, "regular insurance or 80%/20% coverage"	Payment of the patient responsibility for all office visits, procedures, and other charges at the time of the office visit	Check your insurance coverage to determine deductibles, co-insurance, and co-pays. File your insurance claim.
Medicare HMO	All applicable co-pays and deductibles at the time of the office visit	File the claim on your behalf
Worker's Compensation	If we have verified the claim with your carrier, no payment is necessary at the time of the visit. If we are not able to verify your claim payment in full is requested at the time of the visit.	
No Insurance	Payment in full at time of visit	Work with you to settle your account. Please speak to office staff if you need assistance.

ABUSIVE PATIENT POLICY

For the safety of our patients and staff, the Pain, Spine, & Joint Center of the Alleghenies and Pine Grove Ambulatory Surgery Center has a zero tolerance policy for any threatening or abusive behavior, verbal or physical, against anyone in this facility or in the adjacent building. Such behavior will result in the immediate termination of the Provider-Patient relationship.

Printed Name of Patient:_____

Your Name & Relationship to Patient:_____

Patient Signature:_____

Date:_____