Patient Data

Name:(first, middle initial, last):_____

Preferred language: English, Spanish, other_____

Race: white, black, American Indian, Asian, prefer not to answer, other_____

Ethnicity: Hispanic/Latino, non-Hispanics/non-Latino, I do not wish to answer, other_____

Smoking status: never smokers, former smoker, current everyday smoker. Packs per day_____

Allergies:_____

Current medications:_____

_____

Chief Complaint

Why are you here?_____

_____

When and how did it start?_____

_____

What makes you hurt worse?_____

What makes you feel better?_____

Describe your pain: constant, intermittent, dull, sharp, stabbing, ache, other_____

_____

Does your pain go down your arms or legs, if so right or left?_____

Between the numbers *0 (no pain)-10 (in the hospital)* rate your worst and average pain_____/_____

Have you seen another doctor for this problem?_____ If so who?_____

Have you had an x-ray or MRI for this problem?_____ If so where?_____

Have you had a similar problem in the past?_____.If so when?_____

----------Staff Only----------

Ht_____ Wt_____ BP____/____ Resp_____ Pulse_____ O2_____ Preg____