Southwest Ohio Pain Management/Desert Valley Physicians
5700 Gateway Blvd., Suite 100B
Mason, Ohio 45040

# Patient Registration and History Questionnaire

Name: ___________________________________________ Age: _____ Date of Birth: __________ Date: __________
Last First Middle

Address: ________________________________________ City: _____________________ State:____ Zip Code: ________

Social Security #: _______________________ ☐ Male ☐ Female Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children: ______

Home Phone (_____) _________________________________ Work Phone (_____) ___________________________________

Cell Phone (_____) __________________________________ E-mail Address: ________________________________________

Employer: ________________________________________ Spouse's Name: ______________________________________

Occupation: _______________________________________ Spouse's Employer: ___________________________________

Who referred you to this office? ____________________________________________________________________________

**In case of emergency, notify**___________________________________ **Relationship** __________ **Phone** (_____) ______________

Chief Complaint or Reason for Office Visit: ____________________________________________________________________

Specific Date and Time of Onset of Symptoms: __________________________________________________________________

What makes your symptoms better? __________________________ What makes your symptoms worse? _______________________

What is the quality of your symptoms? (ache, burn, dull, sharp, throbbing):___________________________________________________

Are your symptoms local or do they travel to another area? (If they travel, to where?)_________________________________________

Are symptoms; ☐ Constant >76% ☐ Frequent 51-75% ☐ Occasional 26-50% ☐ Intermittent <25% **of your waking hours**

**Please list all medications and dosage**: **Frequency** **For what Illness?**
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

List any allergies to medications, foods or other (if none, write none)_________________________________________________
**Are you pregnant?** ☐ **Yes** ☐ **No**
Do you smoke? ☐ Yes ☐ No: How much? __________________ Do you drink alcohol? ☐ Yes ☐ No; How much________________

**Please list all serious illnesses, surgeries and serious accidents**: **Month and Year** **City, State**
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

**Please list any recent x-rays, lab or other tests**: **Date** **Facility/Doctor**
__________________________________________________________________________________________________
__________________________________________________________________________________________________

**DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?** Check (√) all that apply.

☐ Tuberculosis
☐ Lung Disease
☐ Gout
☐ Diabetes
☐ Kidney Disease
☐ Stomach/Ulcer
☐ Heart Disease
☐ Hepatitis
☐ Sciatica
☐ Blood Pressure
☐ Transfusion
☐ Polio / MS
☐ Colon Disease
☐ Stroke
☐ Cancer
☐ Bleeding
☐ Paralysis
☐ Seizures
☐ Arthritis
☐ Asthma
☐ Anemia
☐ Thyroid Disease
☐ Drug Dependence
☐ AIDS