



# Health & Safety Screen

PLEASE COMPLETE BEFORE YOUR VISIT — PAGE 1 OF 2

PATIENT  DOB  MRN  DATE

Please answer every question. A medical assistant will review your answers with you in the exam room. Leave nothing blank — write "none" if it does not apply.

## Allergies & Reactions to Medications

Drug allergies? ☐ Yes ☐ No ☐ Already listed with our office On file:

| MEDICATION           | REACTION             |
|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |

Reaction to anesthesia (you or a blood relative)?  
☐ Yes ☐ No  
☐ Local ☐ IV sedation ☐ General  
Describe

## Current Medications

Include over-the-counter medicines, vitamins, and supplements. Bring your bottles or a list if easier.

|    | NAME                 | DOSE                 | HOW OFTEN            |     | NAME                 | DOSE                 | HOW OFTEN            |
|----|----------------------|----------------------|----------------------|-----|----------------------|----------------------|----------------------|
| 1. | <input type="text"/> | <input type="text"/> | <input type="text"/> | 7.  | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 2. | <input type="text"/> | <input type="text"/> | <input type="text"/> | 8.  | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 3. | <input type="text"/> | <input type="text"/> | <input type="text"/> | 9.  | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 4. | <input type="text"/> | <input type="text"/> | <input type="text"/> | 10. | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 5. | <input type="text"/> | <input type="text"/> | <input type="text"/> | 11. | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 6. | <input type="text"/> | <input type="text"/> | <input type="text"/> | 12. | <input type="text"/> | <input type="text"/> | <input type="text"/> |

## Safety Screen

These affect whether and how a procedure can be done.

Blood thinner or antiplatelet? ☐ Yes ☐ No Which: ☐ Warfarin ☐ Eliquis ☐ Xarelto ☐ Pradaxa ☐ Plavix ☐ Aspirin  
☐ Lovenox ☐ Other

Who prescribes it, and why?  Phone  Reason

Pacemaker or defibrillator (ICD)? ☐ Yes ☐ No Implanted stimulator or pump? ☐ Yes ☐ No Pregnant? ☐ Yes ☐ No

Diabetes? ☐ Yes ☐ No On insulin? ☐ Yes ☐ No Last A1c, if known

Active infection or fever now? ☐ Yes ☐ No Steroid injection in the last 3 months? ☐ Yes ☐ No Where / when

## Opioid (Narcotic) Medication History

Currently taking an opioid? ☐ Yes ☐ No Medication and dose  Prescribed by

Ever had, from an opioid: ☐ Side effect ☐ Allergic / adverse reaction ☐ Overdose ☐ None Explain

Prior pain physician(s)  Phone   Phone

Discharged by a pain practice? ☐ Yes ☐ No If yes, please explain

Clinic use Reviewed and verified with patient by  Date  ☐ Chart updated

Nicolas Pugh, MD | Adrienne Anders, NP | Ted Chaka, PA

### Abilene Pain Locations

Main: 1925 Hospital Place, Abilene, TX 79606

Additional: 6819 Memorial Dr, Ste B, Abilene, TX 79606

### Contact Numbers

Main: 325-326-3433

Memorial: 325-468-8096

### Online

Email: info@abilenepain.com

Web: www.abilenepain.com



# Medical & Social History

PLEASE COMPLETE BEFORE YOUR VISIT — PAGE 2 OF 2

PATIENT

DOB

MRN

DATE

## Past Medical History

Check every condition you have been diagnosed with.

### Heart & vessels

- ☐ High blood pressure
- ☐ Heart attack
- ☐ Heart failure
- ☐ Irregular heartbeat
- ☐ Heart valve disease
- ☐ Stroke or TIA
- ☐ Blood clot (DVT / PE)
- ☐ Vascular disease

### Lungs

- ☐ Asthma
- ☐ COPD / emphysema
- ☐ Sleep apnea

### Bones & joints

- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Lupus / autoimmune

### Nerves & brain

- ☐ Seizures
- ☐ Neuropathy
- ☐ Migraine / headaches
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Dementia

### Metabolic

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Obesity
- ☐ Adrenal problem

### Kidney & liver

- ☐ Kidney disease
- ☐ Dialysis
- ☐ Kidney stones
- ☐ Hepatitis
- ☐ Cirrhosis / liver disease

### Digestive

- ☐ GERD / reflux
- ☐ Stomach ulcer
- ☐ Crohn's / colitis
- ☐ GI bleeding

### Blood & infection

- ☐ Anemia
- ☐ Bleeding disorder
- ☐ HIV
- ☐ Tuberculosis
- ☐ Cancer (type: \_\_\_\_\_)

### Mental health

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ PTSD
- ☐ ADHD
- ☐ Schizophrenia
- ☐ Substance abuse

Other conditions

Mental health provider

☐ Yes ☐ No

Name

## Past Surgeries

Especially spine, joint, or heart surgery. Include the year.

YEAR

SURGERY

YEAR

SURGERY

## Social History

Tobacco / nicotine

☐ Never ☐ Former ☐ Current Type & amount

Alcohol

☐ Yes ☐ No Drinks/week Marijuana / THC ☐ Yes ☐ No How often

Legal & work status

Working? ☐ Yes ☐ No Lawsuit? ☐ Yes ☐ No On disability? ☐ Yes ☐ No Applied for it? ☐ Yes ☐ No

## Personal & Family History

Asked of every patient. Your answers help us plan safe treatment and are kept confidential.

History of alcohol abuse

YOU

☐ Yes ☐ No

History of illegal drug use

☐ Yes ☐ No

History of prescription drug abuse

☐ Yes ☐ No

History of depression

☐ Yes ☐ No

Diagnosed ADHD, OCD, bipolar disorder, or schizophrenia

☐ Yes ☐ No

A PARENT, SIBLING, OR CHILD

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

Clinic use

ORT score

☐ Low (0-3)

☐ Moderate (4-7)

☐ High (≥8)

Reviewed by

Date

☐ Chart updated

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