- On a scale of 1-10, (10 is the most severe) circle the number that best describes the SEVERITY of your problem or your pain.
  (no problem) 1 2 3 4 5 6 7 8 9 10 (most severe)

- When did you FIRST NOTICE the problem? (When did it start?)
  How many (circle one) days / weeks / month(s) ago: _____

- HOW LONG does each episode last?
  Seconds / Minutes / Hours / Days / Always there
  Describe: _____

- WHEN does this problem happen?
  Daytime / Nighttime / When you are active / Unpredictable
  Describe: _____

- HOW OFTEN are you having the problem or the pain?
  Describe: _____

- What HELPS or what makes the problem WORSE?
  Describe: _____

- Are any OTHER SYMPTOMS occurring at the same time?
  Describe: _____

- List all medication allergies:

- Do you smoke? No Yes How Much?

- Do you use drugs or alcohol? No Yes How Much?

- What is/was your occupation? (What did you retire from?)

- What is your current marital status?
  Single / Married / Seperated / Divorced / Widowed

- List all serious illnesses in your family, including parents, grandparents and siblings. (Diabetes, any kind of cancer, high blood pressure, heart disease, kidney disease or stones, thyroid disease, etc.)

Mother: _____
Maternal GM: _____
Maternal GF: _____
Father: _____
Paternal GM: _____
Paternal GF: _____
Bro./Sis.: _____

- Do you have any of the following problems TODAY? Please mark YES (Y) or NO (N) for EACH item below.