

• 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 / Separated / 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.