Patient Medical Information

Boulder Pain Institute, P.C.

Date: _____ Age: _____ Sex: M F

Name: _____ Date of Birth:_____

Primary Care Physician: _____

Referring Physician: _____

Reason for Visit: _____

When did your pain begin? _____

Is there a specific event that caused your pain? Please explain:_____

Describe your pain: Burning Sharp Shooting Aching Throbbing Electric

Medical History:

Heart disease	Stroke	Liver Disease
Heart attack	Seizures	Thyroid disease
Angina	Chronic Bronchitis	Ulcer disease
Pacemaker	Emphysema	Arthritis
Arrhythmia	Asthma	Depression
High blood pressure	Diabetes	Cancer

List Allergies to medications:

_____ _____

_____ _____

Prescription Medications:

_____ _____

_____ _____

_____ _____

Non-Prescription Medication:

_____ _____