SCCPM Pain Medicine Questionnaire (ENGLISH) SCCPM #5 rev 04/22/23

NAME:_____ **Date:**_____ **Birth Date:**_____

●**Date pain began:** ●**Painful area(s):**

●**Cause(s) of your pain:** ●Pain just began ●Work injury ●Auto accident ●Falling ●After surgery ●Lifting ●Fibromyalgia ●Other: _____

●**Describe the pain:** Aching Sharp Throbbing Burning Cramping ●**Mark your painful area(s)** ——►

●**Pain occurs:** Constantly Intermittently Morning Afternoon Nighttime Other:_____

●**Pain is WORSE:** Sitting Standing Walking Lights Noise Head turning) Using hands ANYTHING

●**Pain is BETTER:** Rest Medications Heat Cold Nothing Other:_____

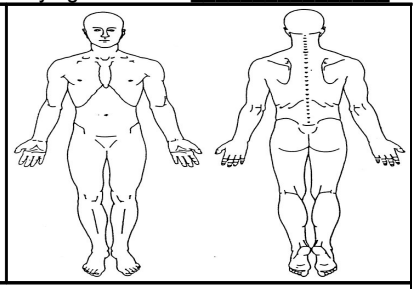
●**Other symptoms:** Numbness Tingling Weakness ●**Loss of control:** bowel bladder

●**DIFFICULT due to PAIN:** daily activities house cleaning driving working sleep having fun sex Other:

●**Your lowest & highest pain scores.** *(0=No pain)* 0 1 2 3 4 5 6 7 8 9 10 *(10=Worse)*

●***Tests completed for pain:*** *MRI CT Xray EMG Labs* ***(Mild)*** ***(Moderate)*** ***(Severe)***

●***Mark PAST pain medications you have tried.*** ●*None*



Narcotics/Analgesics: Hydrocodone/Norco/Vicodin oxycodone/Percocet/Endocet/Oxycontin Tramadol/Ultram Fentanyl Hydromorphone/ Dilaudid/ Avinza Morphine/MSContin Oxymorphone/ Opana Methadone Buprenorphine Butran Acetaminophen/Codeine Nucynta/tapentadol Levorphanol

Anticonvulsants/Nerve Blockers: Gabapentin Neurontin Gralise Pregabalin Lyrica Duloxetine Cymbalta Milnacipran Savella Topiramate Topamax Lamotrigine Lamictal Carbamazepine Tegretol

Muscle Relaxants: Cyclobenzaprine Flexeril Baclofen Carisoprodol Soma Methocarbamol Robaxin Tizanidine Zanaflex Metaxalone Skelaxin

NSAIDs: Ibuprofen Motrin Advil Naproxen Aleve Voltaren Gel Flector Piroxicam Feldene Celecoxib Celebrex Diclofenac Voltaren Etodolac Lodine Meloxicam Mobic Indomethacin Indocin Ketoprofen Ketorolac Toradol Nabumetone Relafen Sulindac Clinoril

Anxiolytics/Sleep: Trazodone Alprazolam Xanax Clonazepam Klonopin Diazepam Valium Lorazepam Ativan Zolpidem Ambien

Restless leg/TCAs: Pramipexole Mirapex Ropinirole Requip Ronirol Amitriptyline Elavil Nortriptyline Pamelor Desipramine Imipramine

Analgesics: Tylenol/ acetaminophen Lidoderm ZTlido Lidocaine Topicial Ketamine **Other/Otro:**

●**Past Treatments:** Physical therapy (Date:_____) Accupuncture Chiropractic Nerve. Blocks Facet Blocks Cortisone Injection Epidural Injection Spinal Cord Stimulator Surgery, Type:_____ **Other**:_____

●**Who has treated your pain?** Primary MD Pain MD Orthopedist Spine Surgeon Neurosurgeon Rheumatologist Neurologist OB/Gyn Others:

●**ORT. Check (√) all that applies to you.**	**2. Personal History of Substance Abuse**	**5. Do you have the following?**
1. Family History of Substance Abuse	( )Alcohol ( )Illegal Drugs *( )Prescription Drugs*	( )Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar Disorder; Schizophrenia. *[F2/M2]*
( )Alcohol *[F1/M3]*	*[F3/M3] [F4/M4] [F5/M5]*	( )Depression*[F1/M1]*
( )Illegal Drugs *[F2/M3]*	***3. ( )Your age is between 16 – 46.****[F1/M1]*	**Score:** RISK:Low(0-3),Mod.(4-7),High(>/= 8)
( )Prescription Drugs [F4/M4]	**4. ( )History of Preadolescent Sexual Abuse** *[F3/M0]*	

●**MEDICAL HISTORY** **Mark your medical problems.** ●NONE *Obesity *Take blood thinner *Glaucoma *High Blood Pressure *Diabetes *High Cholesterol *Heart Attack *Heart Failure *Atrial Fibrillation *Coronary Disease *AICD/Defibrillator *Pacemaker *Hepatitis:B? or C? *Kidney Failure *Kidney Stones *Kidney Disease *Enlarged Prostate *Cirrhosis *Heartburn(GERD) *Stomach Ulcer *Irritable Bowel S. *Sleep Apnea *Asthma *COPD *Blood Clot *Bleeding Prob *Fibromyalgia *Endometriosis *Lupus *Chronic Fatigue Syndrome *Rheumatoid Arthritis *Osteoarthritis *Osteoporosis *Bipolar Disorder *Depression *Anxiety *Attention Deficit Disorder/ADD *Schizophrenia *Alcoholism *Hypothyroidism *Migraines *Multiple sclerosis *Stroke *TIA *Dementia *Parkinson's *Seizures *HIV/AIDS ***Cancer**/Type?:_____ Other: _____

●**SURGICAL HISTORY. List all your past surgeries.** ●None

Type of surgery	Date	Type of surgery	Date	Type of surgery	Date
1.		4.		7.	
2.		5.		8.	
3.		6.		9.	

● **FAMILY HISTORY.** Mark MEDICAL PROBLEMS in your family. (Ex: father, mother, sister, or brother.) ●None

*High Blood Pressure *Diabetes *High Cholesterol Cancer: Other:

●**ALLERGIES** ●None ●Latex ●IV dye/contrast ●penicillin ●**Other**_____

●**CURRENT MEDICATIONS. Indicate the NAME, DOSE (mg), and FREQUENCY (i.e. How many times/day.) ●None**

SOCIAL HISTORY ( )Retired

●**Occupation:** _____( )Unemployed

●**Tobacco Use?** No Yes. If Yes, Packs/day: _____

●**Alcohol?** No Yes. If yes, # Drinks/day:

●**Recreat'l. Drugs?:** No Yes **Present/Past?** Type? marijuana, methamphetamine, cocaine, heroine Other: _____

●**Any claims pending?** No Yes/Type**:** Lawsuit Disability Worker's comp

●**Case is:** Open Closed

●**REVIEW OF SYSTEMS (14 systems). Mark all that apply to you.** ●NONE **Constitutional**: *Fever *Chills *Night sweats *Weight loss **Eyes**: *Visual changes *Double vision **ENT**: *Hearing Problem *Nose bleed *Hoarseness **Cardiovascular**: *Chest pain *Palpitations *Claudication **Respiratory**: *Cough *Short-of-breath **Gastrointestinal**: *Constipation *Bloody stool *Black stool **Genitourinary**: *Menstrual problem *Urinary problem **Musculoskeletal**: *Muscle atrophy *Muscle spasm **Skin**: *Skin rash *Skin ulcer **Neurological**: *Confusion *Dizziness *Poor balance **Psychiatric**: *Anxiety *Depression ( )Under treatment w/ Psychiatrist/ Primary Care Doc **Endocrine**: *Decreased sex drive *Cold Intolerance **Hematologic**: *Bleed easily *Bruise easily **Immunologic**: *Low immunity *Infections: Other symptoms:

●I certify that the above information is true to my best knowledge. **Signature:**_____ **Date:**_____

SOUTHERN CALIFORNIA CENTER FOR PAIN MANAGEMENT- PATIENT REGISTRATION (English) SCCPM#1-3 (Rev: 03/11/24)

Patient Last Name: _____ **First Name:** _____ **M.I.:** _____ **D.O.B.:** _____

Home Address: _____ **Birth Place:** _____

Mailing Address: ( )Same as home _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Primary Insurance Co. Name:_____ **Policy #:** _____ **Subscriber Name:** _____ **Relationship to patient:**_____

Secondary Insurance Co. Name:_____ **Policy #:** _____ **Subscriber Name:** _____ **Relationship to pt:**_____

Social Security #: _____ **Marital Status:** _____ **Occupation:** _____ **Tobacco use:** Yes No Former Never

Sex: M F ( )Choose not to disclose. **Sexual Orientation:** _____ ( )choose not to disclose. **Language:** _____

Race:( )White ( )African American ( )Native Am. ( )Asian ( )Native Hawaiian/Pac. Islander ( )Decline to state **Ethnicity: ( )**Hispanic/Latino ( )Not Hispanic/Latino ( )Decline to State

Emergency Contact Name #1: _____**Phone (Home/Cell):**_____**Relationship:** _____

Emergency Contact #2: _____**Phone(Home/Cell):**_____**Relationship:** _____

Medicare Patient: I request that payment of authorized benefits be made either to me or on my behalf to BRYAN X. LEE, MD, A PROFESSIONAL MEDICAL CORPORATION for any services rendered to me by the physician or his/her associate. I authorize any holders of medical information about me to release to the health care financing administration and its agents any information needed to determine benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act. A Copy of this Signature is as valid as the original.
Commercial Insurance Patient: I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the doctor, or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Patient Authorization/Health Insurance Portability and Accountability Act (HIPAA)

●Please indicate where you want to receive calls or information about your appointments, labs, or other health care issues that would come directly from our staff

Home Phone: _____ Cell Phone: _____ Email: _____

●Can confidential messages (e.g. appointments, labs and results) be left on your voicemail or email? ( )Yes ( )No

●Please list others (names) whom we can inform about your medical conditions & diagnoses:_____

The above authorization will be automatically renewed annually UNLESS patient directs us to change the information.

●**Patient Acknowledgement of Healthcare Information Privacy:** I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; Obtain payment from third party payers; Conduct normal healthcare operations such as quality assessments and physician certifications. I have been informed of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this practice has the right to change its Notice of Privacy Practices from time to time and that I may cause this organization at any time at the address of record to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this acknowledgement in writing at any time, except to the extent that you have taken action relying on this acknowledgement. ●**Penalty Fees & Insurance Member Eligibility Waiver:** missed office appointment is **$50**, missed procedure is **$150**, and "bounced check is **$25**. Verification of your insurance coverage for health care benefits will be performed as a courtesy. However, if your coverage is NOT effective, you will be held responsible for all payments. ●**General Consent:** I hereby consent and request diagnostic procedures/tests and treatment deemed advisable by the professional staff of this practice. I acknowledge that I have read this consent form and understand its contents. I have had an opportunity to discuss it, and any questions I had have been answered to my complete satisfaction.

OPIOID/CONTROLLED MEDICATION AGREEMENT (ENGLISH) SCCPM #4A (rev 03.11.24)

This agreement ONLY applies if you are prescribed Opioids. As part of your pain treatment, Bryan X. Lee, MD and/or his associate(s) may prescribe opioid ("narcotic") or other controlledmedications (e.g. benzodiazepines, anticonvulsants). **This agreement applies only if you are seeing Dr. Lee and/or his medical associate(s) on a REGULAR basis and prescribed OPIOID/CONTROLLED medications.** If you are **transferred/ discharged back** to your primary care or another healthcare provider, then follow the guidelines set forth by him/her. By signing below, the patient agrees to the following: ●I will take the pain medications exactly as prescribed, will not change the dosage or schedule, or mix with other controlled substances/medications without my doctor's approval. I understand that controlled/pain medications, especially if misused, can lead to complications, **including respiratory arrest, heart failure, stroke, paralysis, coma, and death.** ●I will keep regular appointments and call at least 24 hours in advance if I need to reschedule. There may be no early refill of medications. Refills will only be honored during office hours, not weekends, holidays or evenings. ●I will only obtain my controlled pain medications from Dr. Lee and/or his associates. I will not obtain medications from other clinicians unless I am hospitalized or go to the emergency room, in which case I will inform the doctor(s) that I receive pain medications from this practice. In an emergency, if I am given a pain prescription, I will notify this practice as soon as possible. ●I will only use one pharmacy for my pain medications. Lost or stolen prescriptions may not be replaced. I understand there may be no early refills. I agree the pain medications are only for my personal use. Diversion (e.g. selling), abuse, or addiction to the controlled medication(s) may lead to discontinuation of these medication(s) and referral to treatment. ●I agree to abstain from excessive alcohol use and illegal and recreational drug use. I will provide bodily fluid or tissue samples, including urine (full cup), blood, hair, or saliva at the provider's request. There may be random "pill counting" and checking of the state prescription drug monitoring program (PDPM). Presence of illegal drugs or non-prescribed drugs in drug test, noncompliance or inconsistencies in drug testing, pill counting, or the PDMP (e.g. "doctor shopping") may lead to termination of the doctor-patient relationship. ●I give permission for Dr. Lee and/or his medical associate(s) to communicate with other healthcare professionals, family members, law enforcement, and/or regulatory agencies regarding my pain treatment only if necessary. ●Opioid medication may have side effects, including **drowsiness, confusion, constipation, nausea, vomiting, and urinary difficulties**. I will not drive or use heavy machinery if I am drowsy from the medication(s). These medications, if stopped abruptly, may cause withdrawal symptoms including **diarrhea, goose bumps, sweating, anxiety, and abdominal cramps.** ●I understand negative effects of opioid use include **addiction, sexual dysfunction, lowered levels of testosterone and estrogen, osteoporosis (bone loss).** ●I understand that violation of any of the above conditions may result in Dr. Lee and/or his associates discontinuing the use of opioid or other controlled medications, as well as termination of the doctor-patient relationship. My questions have been answered to my satisfaction and I agree to the above guidelines.

By signing below, you certify that all preceding information is correct and true. Furthermore, you have read, understood and agreed to all of the preceding information.

Patient/Guardian Signature_____ **Date**_____ **Witness Signature:** _____