

**FRANK ZONDLO. M.D.**  
**INTERVENTIONAL PAIN TREATMENT CENTER**  
**FORT WALTON BEACH, FLORIDA**  
**(850) 862-2912**

1. Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

MI: \_\_\_\_\_ Date of Birth \_\_\_\_\_

2. Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Male / Female

3. Who referred you to us? \_\_\_\_\_

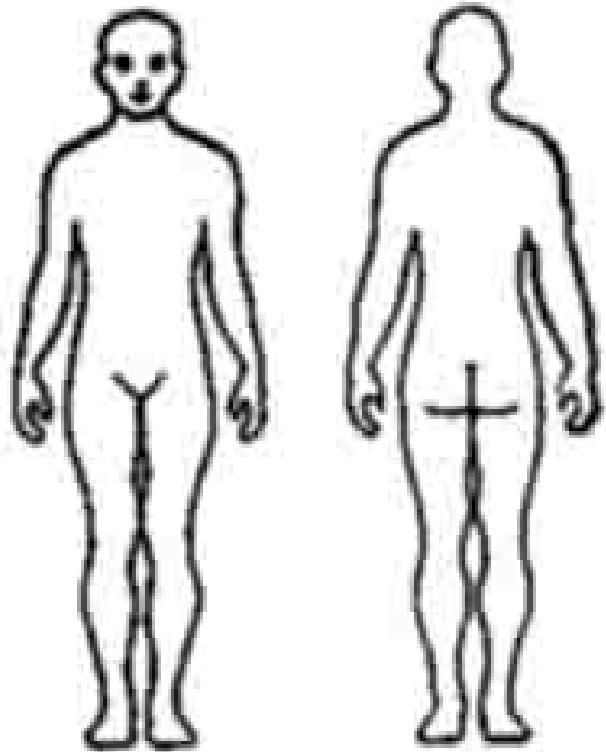
3a. Who is your primary care physician? \_\_\_\_\_

4. Home Address and Phone #: \_\_\_\_\_

5. Circle your pain: **CONSTANT INTERMITTENT DULL SHARP THROBBING NUMBING  
ACHING SHOOTING BURNING TINGLING CRAMPING**

5b. If 10 is the worst pain and 0 is no pain, circle your pain:     **0 1 2 3 4 5 6 7 8 9 10**

5c. Please mark the areas of your pain here:



6. When did you first start having pain? \_\_\_\_\_

7. What caused your pain to begin? \_\_\_\_\_

8. Have you had this pain before? YES / NO When? \_\_\_\_\_ Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

10. Circle what makes the pain worse: WEATHER CHANGES, PHYSICAL ACTIVITY, SITTING, STANDING, WALKING, BENDING, LYING DOWN, BOWEL MOVEMENT, SNEEZING, COUGHING, OTHER: \_\_\_\_\_

\_\_\_\_\_

11. Circle what your pain limits: WORK SLEEP DAILY ACTIVITIES

RECREATIONAL ACTIVITIES

12. Has your pain become more severe? YES / NO

13. What caused it to become more severe, and when? \_\_\_\_\_

\_\_\_\_\_

14. Do you have any areas of tingling (pins and needles) and numbness (loss of sensation)? YES / NO

Where? \_\_\_\_\_

\_\_\_\_\_

15. Do you have any weakness in your arms, legs hands or feet? YES / NO Where? \_\_\_\_\_

\_\_\_\_\_

16. Circle treatments you have had for your pain: PHYSICAL THERAPY, CHIROPRACTIC, TENS UNIT, MASSAGE THERAPY, TRACTION, ACUPUNCTURE, NERVE BLOCKS, EPIDURAL INJECTIONS, TRIGGER POINT INJECTIONS, PSYCHOTHERAPY, SURGERY, BIOFEEDBACK, OTHER \_\_\_\_\_

\_\_\_\_\_

17. Since your pain problem started have you developed loss of bowel or bladder control? YES / NO

18. Do you have Carpal Tunnel Syndrome? YES / NO

19. PAST MEDICAL HISTORY:

Circle any of the following illnesses you have had: STROKE, HYPERTENSION, HEART ATTACK, HEART DISEASE, HIGH CHOLESTEROL, EMPHYSEMA, BRONCHITIS, DEPRESSION, ANXIETY, HEARTBURN - ACID REFLUX, ULCERS, IRRITABLE BOWEL SYNDROME, EPILEPSY, SEIZURE, DIABETES, ENDOMETRIOSIS, CANCER, ARTHRITIS, HEPATITIS - TYPE, AIDS, HERPES, BLEEDING PROBLEMS, GLAUCOMA, HYPOTHYROIDISM.

Please list all other illnesses: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

20. SURGERY HISTORY: Surgeries, Type of Surgery, Date of Surgery

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

21. FAMILY HISTORY: Age and state of health, or Age at Death and Cause of Death

FATHER: Alive/Deceased: \_\_\_\_\_

MOTHER: Alive/Deceased: \_\_\_\_\_

BROTHERS: Alive/Deceased: \_\_\_\_\_

SISTERS: Alive/Deceased: \_\_\_\_\_

22. ALLERGIES: List medicines and types of reactions: eg: nausea, itching, rash, hives, wheezing, palpitations, passing out, other (eg: Medication - Reaction)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_

23. Are you presently taking (Please circle all that apply) **ASPIRIN, COUMADIN, TICLID, LOVENOX, PLAVIX, ANTI-INFLAMMATORY DRUGS** or any other blood thinners? YES / NO

List All Other Blood Thinners: \_\_\_\_\_

24. MEDICATIONS: Please List medications, Dosage, Times per day

1. \_\_\_\_\_
2. \_\_\_\_\_

- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_
- 9. \_\_\_\_\_
- 10. \_\_\_\_\_

25. SOCIAL HISTORY:

Circle your marital status: Married, Single, Divorced, Widowed, Separated

What is or was your occupation? \_\_\_\_\_

Circle your current employment status: **Working (Part time/Full time), Sick leave, Disabled, Retired, Un-employed, Other** \_\_\_\_\_

Do you smoke? YES / NO number of packs per day? \_\_\_ Chew tobacco or dip snuff? YES / NO

Smoke cigars? YES / NO number per day? \_\_\_

Do you drink alcohol? YES / NO Number of drinks per week: \_\_\_\_\_

Have you ever been treated for alcohol or drug abuse? YES / NO If yes, explain: \_\_\_\_\_

26. SYSTEM REVIEW:

Please circle any of the following medical problems you have had:

Constitutional: **Weight change, Fever/Chills, Sleep Disorder, Other** \_\_\_\_\_

Eyes: **Double or blurred vision, Cataracts, Other** \_\_\_\_\_

Ears: Nose, Throat & Mouth: **Hearing Changes/ Deafness, Sore Throat, Sinusitis, Hoarseness, Dizziness, TMJ, Mouth Ulcers, Other** \_\_\_\_\_

Cardiovascular: **Chest pain, Passing Out, Irregular Heart Beat, Ankle Swelling, Other** \_\_\_\_\_

Respiratory: **Shortness of breath, Asthma, Cough, Emphysema, Other** \_\_\_\_\_

Stomach or Bowel: **Change in appetite, Weight change: gain or loss, Abdominal Pain, Diarrhea, Constipation, Other** \_\_\_\_\_

Kidney, Bladder and Reproductive: **Incontinence, Change in stream, Pain on urination, Urine Frequency, Prostate disease, Menstrual, Other** \_\_\_\_\_

Musculo-Skeletal: **Bone Pain, Sprain/Strain, Joint Pain, Joint Deformity, Muscle Pain, Other** \_\_\_\_\_

\_\_\_\_\_  
Skin/Breast: **Rash/ Lumps/ Other** \_\_\_\_\_

Neurological: **Tremmor, Dizzy Spells, Seizures, Memory loss, Headache, Other:** \_\_\_\_\_

\_\_\_\_\_  
Psychologic: **Depression, Anxiety, Panic Attacks, Hallucinations, Other:** \_\_\_\_\_

\_\_\_\_\_  
Endocrine: **Hair loss,Thirst, Energy loss/Fatigue, Other** \_\_\_\_\_

\_\_\_\_\_  
Hematologic/Immunologic: **Bruising, Blood clots, Bleeding, Other** \_\_\_\_\_

27 . LEGAL INFORMATION:

Is your injury workman's comp related? YES / NO

Automobile insurance related? YES / NO

Is there litigation pending with your injury? YES / NO If so, who is your lawyer? \_\_\_\_\_

Do you want us to share information with your lawyer if he contacts us? YES / NO Initial if yes: \_\_\_\_\_

Thank you for completing this questionnaire. At our facility you will undergo an evaluation to determine the source of your pain and the treatment options available. We will make every attempt to fully explain the findings and treatment options. Possible complications vary from procedure to procedure, but may include infection, increased pain, nerve injury, headache, nausea, bleeding, and, very rarely, loss of life or limb. These complications are extremely rare, but have been reported in the medical literature. I have read the above and understand,

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_