DIRECTIONS TO DR. AMIREH'S OFFICE

FROM FREEWAY 41, GO EAST ON HERNDON TO CEDAR.

LEFT ON CEDAR

LEFT ON ELEVENTH (WHICH IS 1ST STOP LIGHT)

TURN RIGHT INTO 4TH DRIVEWAY ON THE RIGHT

OFFICE IS LOCATED AT THE VERY BACK, LAST OFFICE ON THE LEFT

1642 E. HERNDON #106

FRESNO CA, 93720

IF YOU HAVE ANY QUESTIONS CALL OUR OFFICE

(559) 447-1432

******DO NOT GOOGLE, GPS, NOR MAP QUEST OUR ADDRESS BECAUSE IT WILL TAKE YOU TO A DIFFERENT LOCATION******

PLEASE COMPLETE NEW PATIENT PACKET TO THE BEST OF YOUR ABILITY AND BRING WITH YOU THE DAY OF YOUR APPOINTMENT. PLEASE ARRIVE 3O MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT IF YOU HAVE QUESTIONS ON HOW TO FILL OUT THE PACKET. PATIENTS WHO ARRIVE TO THEIR SCHEDULED APPOINTMENTS WITHOUT MAJORITY OF THE PATIENT PACKET COMPLETE WILL BE RESCHEDULED. THANK YOU

Valley Pain Management
New Patient Packet

Patient's Name ____

DOB ________________________________ Date ________________________________

Chief Complaint ____

GENERAL HISTORY

1) **Have you ever had or do you have an allergic reaction to medication or IV dye? ☐ YES ☐ NO**
   If yes please list the medication____
   ____
2) **Do you have a history of MRSA? ☐ YES ☐ NO if yes, what year__________**
3) **Are you seeing a cardiologist? ☐ Yes ☐ No if yes, please list: ___________________________**
4) **Do you have a pacemaker and or AICD/defibrillator: ☐ YES ☐ NO date of implant: __________**
   manufacture: ________________
5) **Are you on any blood thinners? ☐ YES ☐ NO if yes, name of medication__________________**
   and name of the prescribing doctor: ______________________________
6) **Have you had any problems with anesthesia? ☐ YES ☐ NO**

SPECIFIC MEDICAL HISTORY

☐ YES ☐ NO Asthma/COPD
☐ YES ☐ NO Stroke
☐ YES ☐ NO Hepatitis
☐ YES ☐ NO Kidney trouble
☐ YES ☐ NO Diabetes
☐ YES ☐ NO Seizures
☐ Yes ☐ NO Hx. Of Cancer
____

☐ YES ☐ NO Meningitis
☐ YES ☐ NO Paralysis
☐ YES ☐ NO Thyroid Problems
☐ YES ☐ NO High Blood Pressure
☐ YES ☐ NO Heart trouble
Explain in detail: ______________________
____
____
____
Other illness not mentioned? ____________
____

SURGICAL HISTORY

Have you ever had surgery within the last 5 years? Please list: Year

________________________________	______________
________________________________	______________
________________________________	______________
________________________________	______________
________________________________	______________
________________________________	______________

CONTINUE ON BACK PAGE →

Medications: **Please list all medications you are currently taking or bring a list – thank you**

Medication:	Dose:	Frequency:
______________________	_______	___________________________
______________________	_______	___________________________
______________________	_______	___________________________
______________________	_______	___________________________
______________________	_______	___________________________
______________________	_______	___________________________
______________________	_______	___________________________
______________________	_______	___________________________
______________________	_______	___________________________
______________________	_______	___________________________
______________________	_______	___________________________
______________________	_______	___________________________
______________________	_______	___________________________
______________________	_______	___________________________

Please indicate which diagnostic test(s) you have had done:

Test	**When**	**what facility**
Xray	___________	______________________________
MRI	___________	______________________________
CT scan	___________	______________________________
Bone scan	___________	______________________________
NCS/EMG	___________	______________________________
None		

PATIENT DEMOGRAPHICS

DATE: ____________

Last Name: ______________________________ First Name: ____________________

Date of Birth: ________________ Age: _____ Sex: M ____ F_____

Home Phone: ______________________ Work Phone: ________________________

Cell Phone: _______________________SSN: _______________________________

Mailing Address: ____

City: _____________________ Zip Code: _________________________

Email Address: ____

Emergency Contact 1 & Relation: _______________________________ Phone: ____________________

Emergency Contact 2 & Relation: _______________________________ Phone: ____________________

INSURANCE INFORMATION

Primary Insurance: _____________________ Secondary Insurance: ________________

Name of primary holder other than yourself: _________________________ DOB: ____________

Is This Work Related? Yes ___ No____ If yes, what is date of injury? __________

Claim # _________________ Adjuster Name & Number: ____________________________

Is this A Personal Injury Case: Yes ____ No_____ If yes, need Attorney Information:

Attorney_____________________ Phone: ___________________ Fax: _____________________

Responsible Party if Patient under the age of 18: ______________________________________

Referring Physician: ____

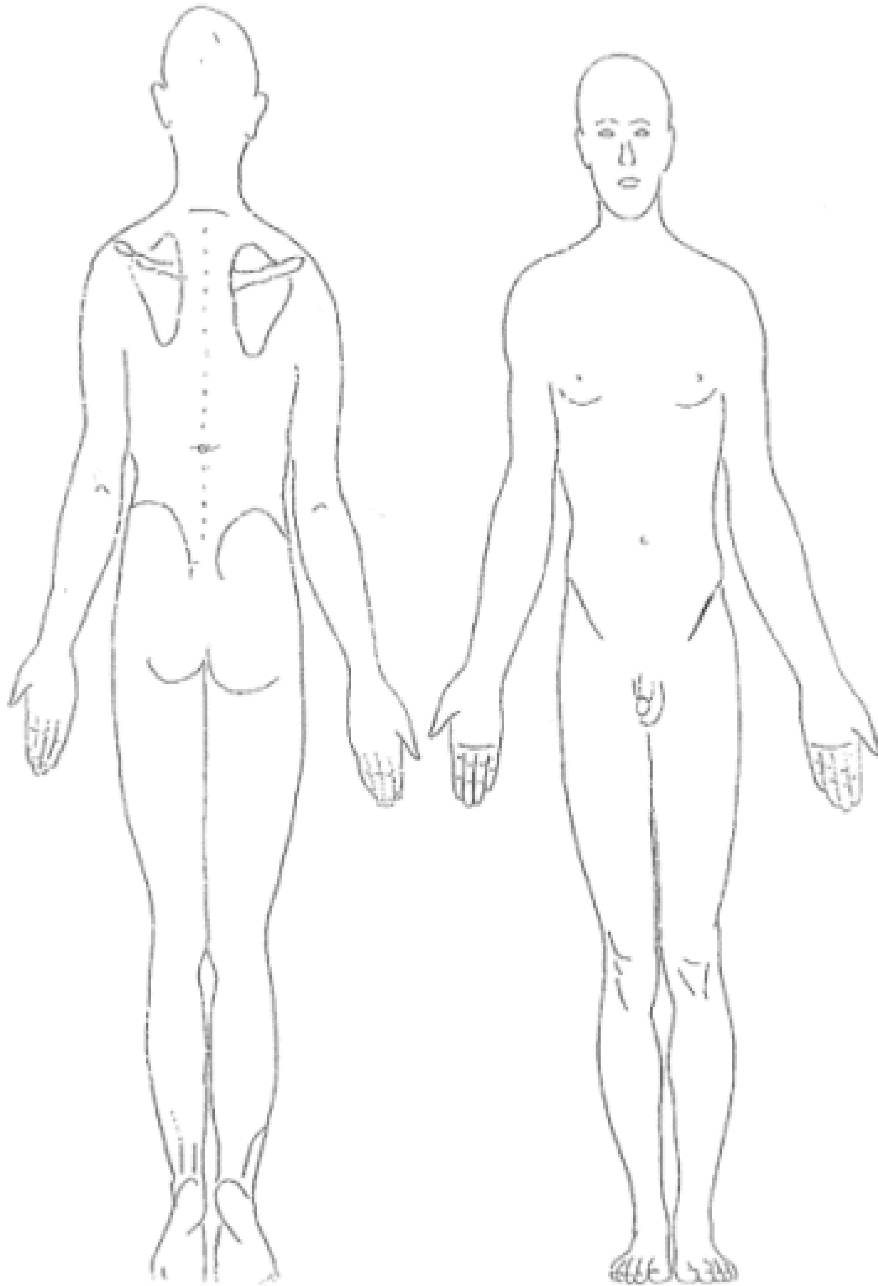
Primary Care Physician: ____

Assignment of Benefits

I understand that this authorization allows the release to Anesthesia Consultants of Fresno of the medical benefits for services rendered.

Signature: ____ **Date:** _______________________

In which part of the body do you feel the pain? (Please indicate in the diagram below).



Chief Complaint: lower or upper extremities

□ Low back pain
□ Low back pain radiating to bilateral LE
□ Low back pain radiating to left LE
□ Low back pain radiating to right LE
□ Neck pain
□ Neck pain radiating to bilateral UE
□ Neck pain radiating to left UE
□ Neck pain radiating to right UE
□ Foot pain
□ Hand pain
□ Other (where) ___________________

Onset of Pain

□ ___/___/____ Date
□ __________ Days
□ __________ Weeks
□ __________ Months
□ __________ Years
□ __________ Other

What triggered your pain

□ Carrying/ Lifting
□ Bending/ Twisting
□ Pushing/ Pulling
□ Fall
□ MVA
Do you have an attorney □Yes □No
Are you presently involved in litigation?
□Yes □ No
□ Other ___________________________

HPI

Pain Level

□ 0- Pain free
□ 1-3 Mild pain
□ 4-6 Moderate pain
□ 7-9 severe pain
□ 10 Extreme/Excruciating pain

Pain Description

Aching	Yes □	No □
Burning	Yes □	No □
Colicky	Yes □	No □
Constricting	Yes □	No □
Cramping	Yes □	No □
Dull	Yes □	No □
Gnawing	Yes □	No □
Sharp	Yes □	No □
Shooting	Yes □	No □
Spasmodic	Yes □	No □
Squeezing	Yes □	No □
Stabbing	Yes □	No □
Throbbing	Yes □	No □
Toothache like	Yes □	No □
Vague Pain	Yes □	No □

Associated Symptoms

Dizziness	Yes □	No □
Fever	Yes □	No □
Headache	Yes □	No □
Joint Pain	Yes □	No □
Muscle Atrophy	Yes □	No □
Muscle Spasms	Yes □	No □
Myalgia	Yes □	No □
Nausea	Yes □	No □
Numbness	Yes □	No □
Tingling	Yes □	No □
Weakness	Yes □	No □
Weight loss	Yes □	No □

Aggravated Symptoms

Any activity or movement Yes □ No □
Describe: ___________________________

Bending over	Yes □	No □
Bending to the side	Yes □	No □
Carrying	Yes □	No □
Climbing Stairs	Yes □	No □
Cold Environment	Yes □	No □
Coughing/Sneezing	Yes □	No □
Doing excessive work	Yes □	No □
Driving	Yes □	No □
Exercise	Yes □	No □
Extension	Yes □	No □
Flexion	Yes □	No □
Head Tilting	Yes □	No □
Heat	Yes □	No □
Keyboard typing	Yes □	No □
Lifting	Yes □	No □
Overhead movement	Yes □	No □
Overhead work	Yes □	No □
Prolonged sitting	Yes □	No □
Prolonged standing	Yes □	No □
Valsalva	Yes □	No □
Walking	Yes □	No □
Sensitive to touch	Yes □	No □

What helps Relieve the Pain

Application of Cold	Yes □	No □
Application of Heat	Yes □	No □
Lying Supine	Yes □	No □
Massaging	Yes □	No □
Medication	Yes □	No □
Rest	Yes □	No □
Sitting	Yes □	No □
Stretching	Yes □	No □

Other comments:

____
____
____
____
____

Treatments Tried

Prescription Medication	Yes □	No □
Heat	Yes □	No □
Ice	Yes □	No □
Physical Therapy	Yes □	No □

For how long:______________________

Tens Unit	Yes □	No □
Acupuncture	Yes □	No □
Chiropractic	Yes □	No □

For how long: ______________________

Neurosurgery	Yes □	No □
Massage	Yes □	No □
Injections	Yes □	No □

What kind: circle one or more:

Lumbar ESI's SI injection facet injections
scs IT pump cervical ESI's

Other:_____________________________

Quality of Sleep

Please circle one:

Poor Normal
Insomnia Unremarkable

REVIEW OF SYMPTOMS

General

Change in appetite	Yes □	No □
Chills	Yes □	No □
Fatigue	Yes □	No □
Fever	Yes □	No □
Night sweats	Yes □	No □
Weakness	Yes □	No □
Weight Changes	Yes □	No □
Flu Vaccination	Yes □	No □

If yes, when: __________

Musculoskeletal

Limitation of movement	Yes □	No □
Muscle cramps	Yes □	No □
Back pain	Yes □	No □
Bone pain	Yes □	No □
Joint pain	Yes □	No □
Muscle pain	Yes □	No □
Stiffness	Yes □	No □
Joint swelling	Yes □	No □

Skin

Change in hair or nails	Yes□	No □
Dry skin	Yes □	No □
Mole changes	Yes □	No □
Rashes	Yes □	No □
Skin discoloration	Yes □	No □
Ulcerations	Yes □	No □
Recurrent skin infections	Yes □	No □

HEENT

Headaches	Yes □	No □
Blurred vision	Yes □	No □
Cataracts	Yes □	No □
Changes in vision	Yes □	No □
Dizziness	Yes □	No □
Double vision	Yes □	No □
Glaucoma	Yes □	No □
Cataracts	Yes □	No □
Hoarseness	Yes □	No □
Nosebleeds	Yes □	No □
Tinnitus	Yes □	No □
Use of hearing aids	Yes □	No □
Vertigo	Yes □	No □

Neck

Neck Pain	Yes □	No □
Stiffness	Yes □	No □
Enlarged thyroid	Yes □	No □

Respiratory

Cough	Yes □	No □
Hemoptysis	Yes □	No □
Nocturnal choking/gasping	Yes □	No □
Shortness of breath	Yes □	No □
TB exposure	Yes □	No □
Wheezing	Yes □	No □

Cardiac

Chest pain Yes □ No □
Edema Yes □ No □
High blood pressure Yes □ No □
Irregular heartbeat Yes □ No □
Palpitations Yes □ No □
Shortness of breath Yes □ No □

Gastrointestinal

Abdominal pain Yes □ No □
Change in bowel habits Yes □ No □
Constipation Yes □ No □
Diarrhea Yes □ No □
Heartburn Yes □ No □
Nausea Yes □ No □
Change in bowel habits Yes □ No □

Urinary

Dysuria Yes □ No □
Frequency Yes □ No □
Hematuria Yes □ No □
Urinary incontinence Yes □ No □
Flank pain Yes □ No □

Neurological

Weakness Yes □ No □
Tingling Yes □ No □
Numbness Yes □ No □
Headaches Yes □ No □
Vertigo Yes □ No □
Dizziness Yes □ No □

Peripheral Vascular

Cramps Yes □ No □
Intermittent claudication Yes □ No □
Varicose Veins Yes □ No □

Endocrine

Heat or cold intolerance Yes □ No □
Excessive sweating Yes □ No □
Diabetes Yes □ No □
Excessive urination Yes □ No □

Psychiatric

Anxiety Yes □ No □
Depression Yes □ No □
Sleep disturbance Yes □ No □
Irritability Yes □ No □
Mood swings Yes □ No □

Social History:

Marital Status: circle one

Married Single
Separated Divorced
Common law Widowed
Domestic partner

Do you smoke Yes □ No□
Caffeine Intake Yes □ No □
Coffee Sodas
Tea Energy drinks

Alcohol intake: circle one

None Occasionally
Seldom daily

Do you consume illicit drugs: Yes □ No □

What is your education level?

Grammar school ____
High School ____
College _____
Post Graduate ____
Other: __________

What is your occupation? Please circle:

Employed Job Title_______________
Unemployed
Worker's Compensation
Permanently Disabled
Other: ______________

THANK YOU FOR FILLING OUT OUR FORMS