

**PAIN THERAPEUTICS PROFESSIONAL ASSOCIATION**

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**HISTORY AND PHYSICAL**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Tests Performed for Pain Problems**

- X – RAYS
- CAT Scan
- MRI
- Bone Scan
- Discogram
- Myelogram
- Other \_\_\_\_\_

**Medications**

\_\_\_\_\_

**Drug Allergies:** \_\_\_\_\_

\_\_\_\_\_

**Past Medical History**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Hospitalizations (Date/Year of Problem Treated)**

\_\_\_\_\_

\_\_\_\_\_

**Review of Symptoms**

\_\_\_\_\_

\_\_\_\_\_

**Family Medical/Social History**

**Family Disease History:** \_\_\_\_\_

**How many people in household:** \_\_\_\_\_

**Smoker:** \_\_\_\_\_ Yes \_\_\_\_\_ No / If yes, how much? \_\_\_\_\_

**Alcohol:** \_\_\_\_\_ Yes \_\_\_\_\_ No / If yes, how much? \_\_\_\_\_

**Ever had a problem with alcohol?** \_\_\_ Yes \_\_\_ No (DUI, injury, break-up)

**If yes, when did you quit?** \_\_\_\_\_

Patient's name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Where is your worst pain? (Chief Complaint):

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Please mark the areas you feel pain on the drawings. Put an "E" if it is external or an "I" if it is internal next to the areas that you have pain. Put an "EI" if the pain is both internal and external.

