JOSE G. VELIZ MD, INC.
Diplomate of the American Board of Interventional Pain Management
Diplomate of the American Board of Anesthesiology
Diplomate of the American Board of Pain Medicine
Fellow of Interventional Pain Practice

INTERIM HEALTH HISTORY

Patient Name: ________________________________ Birthdate: ___________Today's Date: _________

Do you have a new home address Yes No ____

Do you have a new telephone number Yes No Home:_______________**Cell:**___________________

Do you have new health insurance Yes No ____

What is the main area of your pain today? ____

What is your pain scale presently? 0 1 2 3 4 5 6 7 8 9 10

Since your last visit, has your pain level: ____ Increased _____ Decreased _____ Stayed the Same

Are you involved in physical therapy, chiropractic, massage therapy or other treatments?
____

If so, how has it affected your pain? _____ Better _____ Same _____ Worse
When is your pain worse? ____ Morning _____ Afternoon _____ Night _____ All the Time

Associated with my pain, I also have or am experiencing: _____ Loss of Coordination ____ Weakness

____ Loss of Dexterity _____ Increased Sensitivity _____ Decreased Sensitivity _____ Numbness

Have you experienced any of the following symptoms since your last visit?

____ Fatigue ____ Diarrhea ____ Fever ____ Constipation ____ Insomnia ____ Nausea _____ Heartburn
____ Loss of Appetite ____ Serious Depression ____ Chest Pain (Angina) ____ Aggression ____ Dizziness
____ Hostility _____ Shortness of Breath ____ Mood Swings

Since your last visit, have you:

1) Seen any other doctors? [ ] yes [ ] no If so, whom? ____

2) Had any other diagnostic tests? [ ] yes [ ] no If so, which tests and where did you have them done?
____

3) Started any new treatments? [ ] yes [ ] no If so, what treatment and who ordered it?_________________
____

4) Started taking any new medications? [ ] yes [ ] no If so, which ones and at what dosage? _______________

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Are any of them blood thinners? [ ] yes [ ] no If so, which ones?______________________________

5) Developed any new allergies? [ ] yes [ ] no If so, which ones? ______________________________

6) If Female: Are you Pregnant? [ ] yes [ ] no. Is there a chance you may be Pregnant? [ ] yes [ ] no

7) Had any surgeries? [ ] yes [ ] no. If yes, what kind? ______________________________

8) Developed any new medical problems from the following list? Please "X" any that apply:

[ ] depression or anxiety
[ ] pulmonary embolus
[ ] major blood vessel
[ ] congestive heart failure
[ ] bleeding tendency
[ ] abnormal heart rhythm
[ ] high blood pressure
[ ] chronic bronchitis
[ ] joint disease or arthritis
[ ] deep venous thrombosis
[ ] peripheral vascular disease
[ ] thyroid disease
[ ] kidney disease
[ ] urinary tract infections
[ ] seizures/epilepsy
[ ] rheumatoid arthritis
[ ] ulcer or stomach problems
[ ] other nervous system diseases
[ ] shingles
[ ] syphilis
[ ] lupus
[ ] asthma
[ ] emphysema
[ ] heart attack
[ ] liver disease
[ ] tuberculosis
[ ] cancer. What type?______________
[ ] hepatitis
[ ] chicken pox
[ ] meningitis
[ ] osteoporosis
[ ] stroke
[ ] diabetes
[ ] osteoarthritis
[ ] pancreatitis

9) Who is your primary care physician? ______________________________

If available Phone #: ( ) ________________ Fax #: ( ) ________________

LIST OF MEDICATIONS**

Name of Medication: ________________
Dosage (mg.): ________________
Directions: ________________

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Directions: ________________

****Use the back of this sheet for additional medications**

*****PLEASE ALLOW 72 HOURS FOR RETURN CALLS REGARDING MEDICATION*****