

Bend Spine and Pain Specialists

Confidential Health Questionnaire-Fibromyalgia Program

Patient Name _____ Date _____

Date of birth _____ Marital status: S M D W Sex: M F

Medication - What are your current medications?

Dose

Frequency

Years

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

Do you have any allergies or bad reactions to medications?

Medical History

Prior Medical Problem

Years

_____	_____
_____	_____
_____	_____
_____	_____

Prior Hospitalizations

Reason for hospitalization

Date

_____	_____
_____	_____
_____	_____
_____	_____

Prior Surgeries

Type of Surgery

Surgeon

Date

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Psychiatric History

Do you have a psychological diagnosis? _____

Have you often been bothered by feeling down, depressed, or hopeless? _____

Have you been bothered by little interest or pleasure in doing things? _____

Substance Abuse History - Are you currently using? How often?

Marijuana _____ Medical Marijuana _____ Cocaine _____

Meth _____ Barbiturates _____ Heroin _____

Pills not prescribed to you? _____ Other drugs _____

Do you smoke or use tobacco? _____ How much _____ Years _____

Alcohol _____ Number of drinks/day _____

Have you had more than 5 drinks in one setting within the past 3 months? _____

Ever thought you should cut down on your alcohol/drug use? _____

Have people annoyed you, criticizing your alcohol/drug use? _____

Ever felt guilty about your alcohol/drug use? _____

Ever have an "eye-opener" first thing in the morning? _____

Ever get arrested or in trouble, miss work because of alcohol/drug use? _____

Social History

Are you employed? _____ What do you do? _____

Are you married? _____ Children? _____ What is your education level? _____

Hobbies _____

Family History - Who in your family has:

Alcoholism _____ Substance Abuse _____

Depression _____ Cancer _____

Heart Disease _____ Stroke _____

Diabetes _____ Hypertension _____

Quality of life Scale – How well do you Function?

- 0 I stay in bed all day
- 1 I sometimes get out of bed and move about the house
- 2 I get out of bed in the morning, but I don't get dressed, I stay at home all day
- 3 I get dressed in the morning, minimal activity at home
- 4 I do simple chores around the house only
- 5 I am able to fulfill all daily home responsibilities, I get out socially occasionally
- 6 I can do chores inside and outside the house, I am out frequently
- 7 I work or volunteer part time and I'm active at least 5 hours a day
- 8 I work or volunteer full time, fulfill all obligations, chores, and responsibilities
- 9 I work or volunteer full time and exercise occasionally
- 10 I work or volunteer full time and exercise regularly

New Fibromyalgia Patient History

*Please completely fill in bubbles with blue or black ink.

1. When did your pain begin? <3 months >3 months

2. Where is your pain? _____ ●

3. What does your pain feel like?
 ache cramp sharp dull numbness weakness pins & needles burning other

4. What makes your pain worse?
 laying standing sitting exercise other none

5. What makes your pain better?
 laying standing sitting exercise other none

6. Are you currently taking or have taken in the last 2 weeks:
 pimozone (Orap) thioridazine (Mellaril) triptans (Axert, Frova, Maxalt, Imitrex, Zomig)
 warfarin (Coumadin) isocarboxazid (Marplan) tranylcypromine (Parnate) phenelzine (Nardil)
 rasagiline (Azilect) (Eldepryl, Emsam) none

7. Have you been diagnosed with:
 Autoimmune disease Chronic fatigue syndrome Lyme disease Thyroid disorder

8. Do you have difficulty concentrating? yes no

9. Do you have restless leg syndrome? yes no

10. If yes, does your restless leg syndrome keep you from sleeping? yes no

11. Do you have poor quality sleep? yes no

12. Do you have sleep disturbances? yes no

13. What type of treatment have you received for Fibromyalgia?
 Alternative treatments (acupuncture, massage, etc) Cognitive Behavioral Therapy Medication
 PT/OT TENS unit other none

14. What type of exercise are you currently doing?
 biking swimming walking yard work yoga none

15. How many minutes per week do you exercise?
 0 minutes <30 minutes 30-60 minutes 60-120 minutes >120 minutes

16. What is your employment status?
 Disabled Full time Home maker Part time Retired Student

17. Are you currently sexually active? yes no

18. Are you currently experiencing:
 Depression/Anxiety Fatigue Generalized pain Headaches Frequent urination
 Constipation/Diarrhea Numbness Swollen hands/feet sleep disorder Stiffness Tingling