



ARIZONA PAIN MANAGEMENT & REHABILITATION

Estelle R Farrell D.O.

PAST MEDICAL HISTORY

Patient Name _____ Age _____ Date _____

Medical

None Diabetes Asthma High Blood Pressure Cancer Heart Disease High Cholesterol
 Anxiety Depression
Other _____

Surgical

None Tonsillectomy Appendectomy Hysterectomy Hernia Gall Bladder C-Section
 Arthroscopy Colonoscopy Other _____

Allergies to medication

None Yes If yes, please explain _____

Current prescriptions and over the counter medications None See attached list

Name of Prescription/OTC/Herb	mg dose	#tablets/ per day	problems	Prescribed By
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Patient Signature _____ Date _____ Physician Signature _____ Date _____



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Patient Name _____ Age _____ Date _____

Family History

Father Living ___Age Deceased ___Age _____ Cause

Mother Living ___Age Deceased ___Age _____ Cause

Siblings' ___Number of Living ___Number of Deceased
_____ Cause

Children ___Number of Living ___Number of Deceased
_____ Cause

Other Illnesses in family _____

Social History

Single Married, Years____ Widowed Divorced, Spouse's Name_____

Smoke No Yes/Previously

_____ #Packs/day _____ # of Years Stopped Smoking? Date _____

Alcohol None Rarely Occasional wine with dinner Weekends

1-2 Drinks per day More than 2 per day

OTC Drugs None Aspirin Tylenol Ibuprofen Aleve Tums Maalox Mylanta Pepcid AC
Allergy

Exercise None Yes What and how frequently? _____

Substance Abuse None Marijuana IV Drug Abuse Other _____

Patient Signature Date Physician Signature Date