

List ALL Medications you are now taking:

Name: Robert Plk Date of Birth: 07/26/1968

Medication:	Dose	How many per day	Please List any medications which you have tried which did not help your pain:
<u>Tylenol</u>	<u>500</u>	<u>8</u>	
<u>Aspirin</u>	<u>5/325</u>	<u>2</u>	
<u>Ibuprofen</u>	<u>600</u>	<u>3</u>	
<u>Hand Cream</u>		<u>2 times</u>	
<u>Rash</u>			

Have you had side effects from pain medications?

Medicine Side Effect

ALLERGIES TO MEDICATIONS:

NO

Family History:

Living Deceased

☒
☒
☒
☒
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Family Member

Mother
Father
~~Brothers~~
Sisters
Children

Please list their major health problems

Diabetes
Thyroid

Diabetes / Heart

Personal History: HVAC

Occupation: Service Technician

Currently Working? Yes ☒ No ☐

Are you receiving disability? Yes ☐ No ☒

Disability diagnosis: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☒ Widowed

Do you live ☒ independently or ☐ do you require home health assistance or ☐ in an assisted facility?

Do you smoke? Yes ☐ No ☒ Amount: _____

Do you drink alcohol? Yes ☒ No ☐ Amount: 2 weeks

Do you use illegal drugs? Yes ☐ No ☒ Describe: _____

Did you, within the past year, want or need to cut down on controlled substance use? Yes ☐ No ☒

Have you been annoyed or angered by someone else complaining of your drug or alcohol use? Yes ☐ No ☒

Have you felt guilty about the consequences of prescription drug or alcohol use? Yes ☐ No ☒

Do you use a drug or alcohol in the morning as an "Eye opener" for "withdrawal" or a hangover? Yes ☐ No ☒

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05/23/2013