Dr. Sana-Ara Ahmed MD FRCPC

Anesthesiology | Interventional Complex Chronic Pain | Regenerative Medicine | Cannabinoid Medicine Specialist

Confidential

Your Personal Information: Please make sure to provide a valid email address.

Print Name: _____
First Last

Address: _____
Street, City, Province, Postal Code

Phone #'s: _____ ☐/☐ _____ ☐/☐
Home Ok to leave VM? Mobile Ok to leave VM?

E-mail: _____+

Family Doctor/Medical Clinic: _____Phone: _____

Alberta Health Card # _____ Date of birth MM/DD/YY: _____

Current Gender Identity? ☐ Male ☐ Female ☐ Transgender Male/Transman/FTM
☐ Transgender Female/Transwoman/MTF ☐ Gender Queer ☐ Decline to answer ☐ Other

Emergency Contact/Relation Phone: _____ Emergency Phone #: _____

Health Insurance Company: _____

Name: _____ Group #: _____

Family/Social History - Please check off any that apply (multiple checks are good to know)

Are you: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐

Are you: Employed ☐ Self-employed ☐ Unemployed ☐

Are you on currently on income assistance or short-term disability:

- ❑ Income Assistance – Federal Name: _____
- ❑ Income Assistance – Provincial Name: _____
- ❑ Veteran: VACID: _____
- ❑ WCB: Claim#: _____
- ❑ Disability Insurance Name: _____

Was this a WORKPLACE injury that is causing you pain? Yes / No

If yes, please explain when and how?_____

Was this injury due to a car accident that is causing you pain? ☐ / ☐

If yes, please explain when the accident occurred and how the accident happened?

_____

_____

_____

Family History:

- ❑ Father:_____
- ❑ Mother:_____
  _
- ❑ Sibling(s): _____
- ❑ Grandparents:_____
- ❑ Aunts/Uncles/Cousins:_____

Past Surgical History - Please check off any that apply (multiple checks are good to know) Please add date and type of surgery in space provided.

- ❑ Neurosurgery: _____
- ❑ Dental/Jaw/OralMax Surgery: _____
- ❑ Cervical Neck: _____
- ❑ Abdominal: _____
- ❑ Back Surgery: _____
- ❑ Joint Replacement: _____
- ❑ Joint Arthroscopy:_____
- ❑ Pelvic Surgery:_____

Past Medical Health History - Please check off any that apply (multiple checks are good to know)

Have you been recently or previously diagnosed with cancer/malignancy?

- ❑ Type of Cancer: _____
- ❑ Location of Cancer: _____
- ❑ Chemo/Radiation Dates: _____
- ❑ Surgery Plans: _____

Are you currently pregnant or planning a pregnancy or postpartum?

- ❑ Gestational Age (weeks): _____
- ❑ OB/GYN Name & Clinic Fax:
  _____

❑ Due Date: _____

❑ Breastfeeding Plans: _____

Neurological Health	**Respiratory Health**	**Cardiovascular Health**
❑ Dizziness/Balance problems ❑ Vision problems ❑ Hearing loss ❑ Seizure/epilepsy disorder ❑ Myasthenia Gravis ❑ Parkinson's Disease ❑ Multiple Sclerosis ❑ Migraines ❑ TBI/Post-Concussions ❑ Post-Herpetic Neuralgia ❑ Trigeminal Neuralgia ❑ Stroke/Post-Stroke Pain ❑ Guillain Barre Syndrome ❑ Spinal Cord Injury ❑ Memory Loss/Dementia	❑ Shortness of breath/chest pain ❑ COPD ❑ Bronchitis ❑ Asthma ❑ Emphysema ❑ Do you smoke ? ☐ N ☐ ❑ How much per day? ❑ Are you on Home Oxygen therapy? ☐ /I ☐ ❑ How much Oxygen are you on? ❑ Do you use a CPAP machine?	❑ High blood pressure ❑ Low blood pressure ❑ Congestive heart failure ❑ Chest pain (angina) ❑ History of heart attack (MI)I ❑ Bypass Grafting/Angioplasty ❑ Atrial Fibrillation ❑ SVT ❑ Heart Disease ❑ Pacemaker or ICD ❑ Valvular Heart Disease ❑ Heart Surgery: _____ ❑ Current Blood thinners: ❑ Warfarin ❑ Dabigatran ❑ Plavix ❑ Heparin ❑ LMWH ❑ Aspirin
Mental Health	**GI Health**	**Women's Reproductive Health**
❑ Sleep Disorders/ Insomnia ❑ Restless Leg Syndrome ❑ Nightmares ❑ Panic Attacks ❑ Agoraphobia ❑ Generalized Anxiety Disorder ❑ PTSD ❑ Depression ❑ Suicidal Attempt Recent/Past ❑ Adjustment Disorder ❑ Bipolar Disorder ❑ Schizophrenia/ Psychosis ❑ Eating Disorder/Anorexia/Bulimia ❑ Autism Spectrum Disorder	❑ Abdominal Pain ❑ Nausea/ Vomiting ❑ Constipation ☐ / ☐ Bowel Movements Frequency per week/per month?_____ ❑ Diarrhea Yes / No Frequency per day?_____ ❑ Ulcerative Colitis/IBD/Crohn's Disease ❑ Irritable Bowel Syndrome ❑ Celiac Disease ❑ Hepatitis/ Liver Disease ❑ Pancreatitis	❑ Pelvic Pain/ Gonadal Pain ❑ Vaginal Discharge ❑ Menstrual Irregularity ❑ Heavy Menstrual Bleeding ❑ PCOS ❑ Endometriosis ❑ Premenstrual Syndrome ❑ Hot flashes ❑ Dyspareunia-Painful Intercourse **Men's Genitourinary Health** ❑ Enlarged Prostate ❑ Urinary Bladder Pain ❑ Blood /Pus in urine ❑ Increased frequency of urination

❑ ADHD/ ADD ❑ Other:_____ _____ _____	❑ Colorectal Disease/Diverticulitis	❑ Night time urination ❑ Poor Stream ❑ Incontinence ❑ Sexual dysfunction

Do you snore loudly? Louder than talking, or to be heard through closed doors?

- ❑ YES
- ❑ NO

Do you often feel tired, fatigued, or sleepy during the daytime?

- ❑ YES
- ❑ NO

Has anyone observed you stop breathing during your sleep?

- ❑ YES
- ❑ NO

Do you have, or are you being treated for HTN?

- ❑ YES
- ❑ NO

Is your BMI greater than 35?

- ❑ YES
- ❑ NO

Are you over 50 years old?

- ❑ YES
- ❑ NO

Is your neck circumference greater than collar size 16(41cm) for women and 17(43cm)?

- ❑ YES
- ❑ NO

Medication Review - Please check off any that apply (multiple checks are good to know)

Please list all current medications and previous medication and **indicate how helpful they have been on a scale of 1 to 10 (1 being not helpful at all, 10 being the most helpful).**

Medication Name (Ex: Tylenol ES)	**Administration Dose and Time Prescribed** (Ex: 500mg 1 tablet 4 times a day)	**Scale 1 to 10**

Medication Review **- Are you currently using Medical Cannabis? If Yes, please answer the following:**

- ❑ How long? _____
- ❑ How many grams per day? _____
- ❑ Preferred name of strain? _____
- ❑ Preferred license producer? _____
- ❑ Current Medical Doctor prescribing for you? _____
- ❑ Do you own a vaporizer?
- ❑ CBD use currently: _____
- ❑ THC use currently: _____

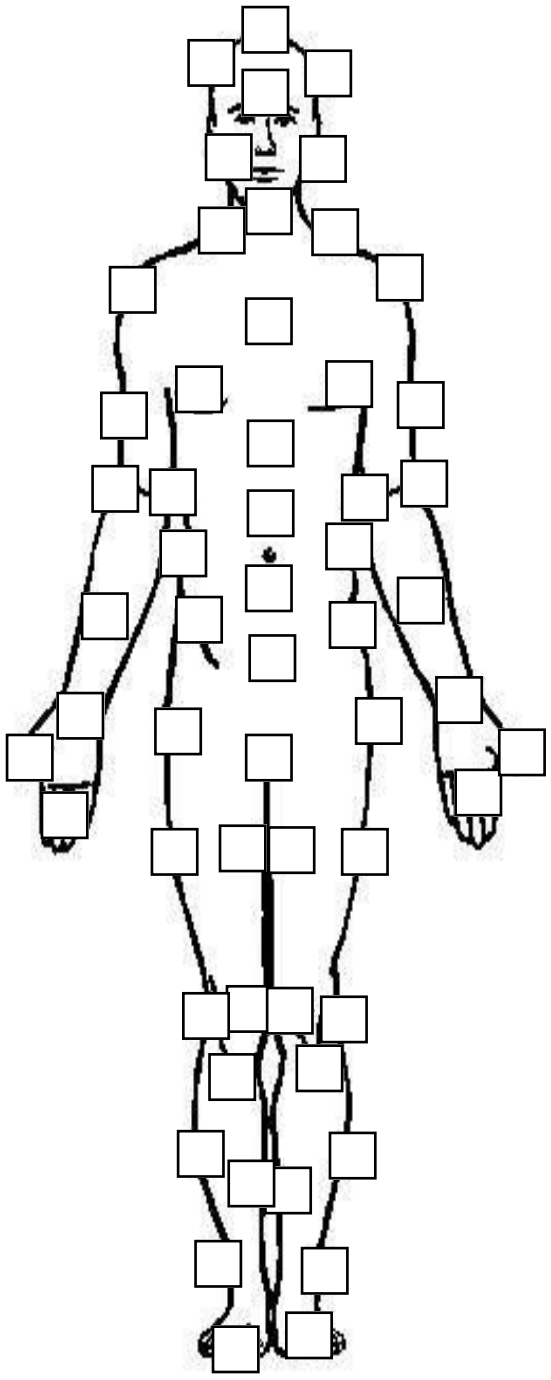
Substance Risk of Abuse Review **- Please answer these questions to your best ability. There is no judgement or risk in answering this question; it will only help Dr. Ahmed provide you with the safest possible care when prescribing opioid medications if required.**

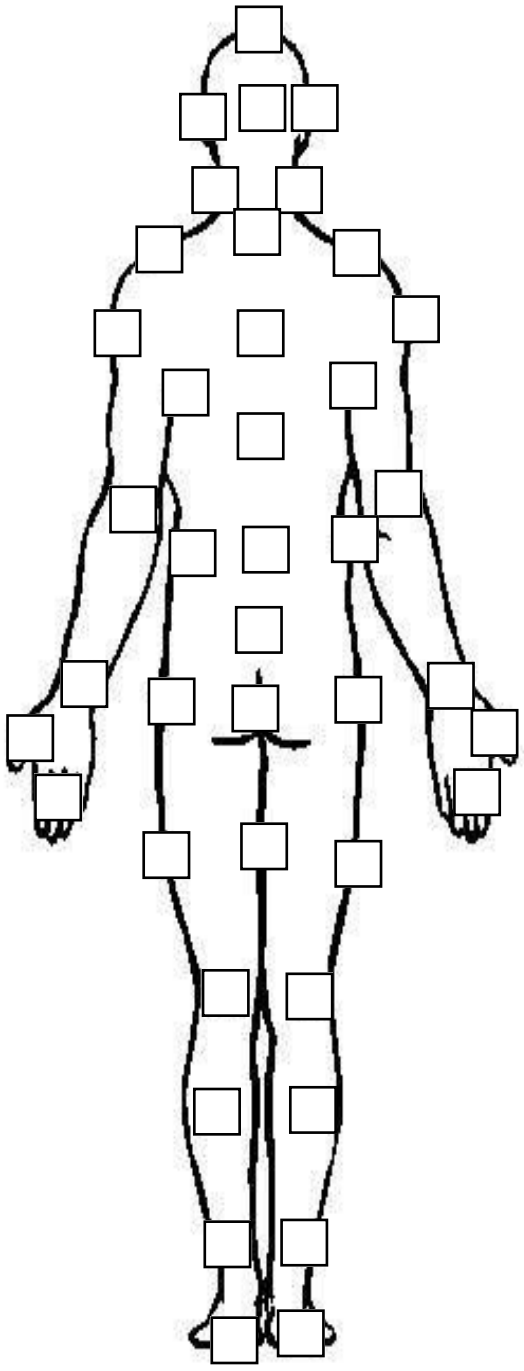
Question	Female	Male
1. Family History of Substance Abuse:		
Alcohol	1 ◯	3 ◯

Illegal Drugs	2 ◯	3 ◯
Prescription Drugs	4 ◯	4 ◯
2. Personal History of Substance Abuse:		
Alcohol	3 ◯	3 ◯
Illegal Drugs	4 ◯	4 ◯
Prescription Drugs	5 ◯	5 ◯
3. Age (mark box if 16-45)	1 ◯	1 ◯
4. History of Preadolescent Sexual Abuse	3 ◯	0 ◯
5. Psychological Disease Attention Deficit Disorder, Obsessive-Compulsive Disorder, Bipolar, or Schizophrenia	2 ◯	2 ◯
Depression	1 ◯	1 ◯
Total		

Draw with "XX" on the diagram the location of your Pain:

If using fillable PDF- Please "check" off closest location on diagram





Location of Joint Pain/Muscle Pain	Location of Joint Pain/Muscle Pain
☐ **Cervical Neck** ☐ With arm pain ☐ Without arm pain ☐ With shoulder pain	☐ **Knees L / R** ☐ above knee ☐ below knee ☐ at joint

- ❑ Without shoulder pain
- ❑ With headaches
- ❑ Without headaches

❑ **Jaw/TMJ**
- ❑ with headaches
- ❑ without headaches

❑ **Intercostal/Sternum/Rib Pain**
- ❑ with breathing
- ❑ without breathing
- ❑ burning pain

❑ **Thoracic vertebrae**
- ❑ spinal cord tumors
- ❑ post surgical pain

❑ **Lumbar Back**

❑ sacroiliac joint dysfunction

❑ tailbone/coccyx pain

❑ facet joint arthritis→pain

❑ spinal stenosis

❑ disc herniation: L_____

❑ with burning pain down legs

❑ without burning down legs

❑ with spasms and burning pain in buttocks

❑ without spasms and burning pain in buttocks

❑ Date of last Epidural Injection:

❑ Date of last Facet Joint Injections:

❑ Date of last Radiofrequency Ablation:

❑ **Hips**
- ❑ Pain on side of hip down to knee
- ❑ Burning pain
- ❑ Inside joint
- ❑ Inside groin
- ❑ In buttocks and down into groin
- ❑ In buttocks and down side of leg
- ❑ left side of knee
- ❑ right side of knee

❑ **Ankles L / R**
- ❑ while walking
- ❑ while climbing

❑ **Feet L / R**
- ❑ on top
- ❑ below

❑ **Shoulders L / R**
- ❑ Rotator Cuff injury
- ❑ Pain in muscles of shoulders
- ❑ Pain in shoulder and arm together
- ❑ Pain in armpit

❑ **Wrists L / R**
- ❑ Carpal Tunnel Syndrome
- ❑ broken bone in past

❑ **Hands L / R**
- ❑ fingers
- ❑ thumbs

Autoimmune Joint Pain:

❑ Ehler Danlos Syndrome

❑ Rheumatoid Arthritis

❑ Ankylosing Spondylitis

❑ Systemic Lupus Erythematosus(SLE)

❑ Psoriatic Arthritis

❑ Sarcoidosis

❑ Dermatomyositis

❑ Polymyalgia Rheumatica

❑ Polymyositis

❑ Scleroderma

❑ Any other Autoimmune disease , please specify_____

Past use of non-pharmacological pain management (includes physiotherapy, massage, chiropractic, acupuncture, reiki, alternative healing therapies).

_____

_____

_____

_____

_____

Brief Pain Inventory **- Pain Level 0 = No Pain 10 = Bad as you can imagine - add comments where necessary**

Questions	Comments
What is the present pain level?	
What do you rate your pain when it is at its least?	
What makes pain better?	
What do you rate your pain when it is at its worst?	
What makes pain worse?	
Is the pain continuous or intermittent?	
When did the pain start?	
What do you think is the cause of the pain?	

Quality: Indicate the words that describe the pain

Aching ☐	Throbbing ☐	Shooting ☐	Stabbing ☐	Gnawing ☐	Sharp ☐
Burning ☐	Tender ☐	Exhausting ☐	Pulling/Tuggin ☐	Penetrating ☐	Numb ☐
Nagging ☐	Hammering ☐	Pins & Needles ☐	Pain to Light Touch ☐	Tingling ☐	Deep ☐

Symptoms: What other symptoms are being experienced?

Constipation ☐	Nausea ☐	Vomiting ☐	Fatigue ☐	Insomnia ☐	Depression ☐
Drowsy ☐	Sore mouth ☐	Weakness ☐	Shortness of breat ☐	Other:	

Behaviours: What behaviours are present that may be a result of pain or treatment of pain?

Calling out ☐	Restlessness ☐	Disorientation ☐	Not eating ☐	Pacing ☐
Not sleeping ☐	Withdrawn ☐	Groaning/moaning ☐	Rocking ☐	New immobility ☐
Tense ☐	Distressed ☐	Distracted ☐	Crying ☐	Inexpressive ☐
Fists clenched ☐	Striking out ☐	Knees pulled up ☐	Frowning ☐	Facial grimacing ☐
Resistant to movement ☐	Pulling or pushing away ☐	Sad ☐	Frightened ☐	Other:

ADLs: What are the effects of pain on your activities of daily living?

Activities of daily living	Yes	No	Comments
Sleep and rest	☐	☐	
Social activities	☐	☐	
Appetite	☐	☐	
Physical activity & mobility	☐	☐	
Emotions	☐	☐	
Sexuality / intimacy	☐	☐	

Brief Sleep Inventory - Please answer the following questions to the best of your ability by circling your answer

During the **past month**, how would you rate your sleep quality **overall?**

Options include, please pick one: Very good (0) Fairly good (1) Fairly bad (2) Very bad (3)

During the **past month**, how often have you had trouble sleeping because you cannot get to sleep within 30 minutes

Options include, please pick one: Not during the past month (0) **Less than once a week (1) Once or twice a week (2) Three or more times a week (3)**

During the **past month**, how often have you had trouble sleeping because you wake up in the middle of the night or early morning

Options include, please pick one: Not during the past month (0) **Less than once a week (1) Once or twice a week (2) Three or more times a week (3)**

During the **past month**, how often have you had trouble sleeping because you have to get up to use the bathroom

Options include, please pick one: Not during the past month (0) **Less than once a week (1) Once or twice a week (2) Three or more times a week (3)**

During the **past month**, how often have you had trouble sleeping because you cannot breathe comfortably and/or snore loudly

Options include, please pick one: Not during the past month (0) **Less than once a week (1) Once or twice a week (2) Three or more times a week (3)**

During the **past month**, how often have you had trouble sleeping because you are either too hot or too cold?

Options include, please pick one: Not during the past month (0) **Less than once a week (1) Once or twice a week (2) Three or more times a week (3)**

During the **past month**, how often have you had trouble sleeping because you are experiencing pain?

Options include, please pick one: Not during the past month (0) **Less than once a week (1) Once or twice a week (2) Three or more times a week (3)**

During the **past month**, how often have you had trouble sleeping because you experience bad dreams?

Options include, please pick one: Not during the past month (0) **Less than once a week (1) Once or twice a week (2) Three or more times a week (3)**

During the **past month**, how often have you taken medicine (prescribed or "over the counter") to help you sleep?

Options include, please pick one: Not during the past month (0) **Less than once a week (1) Once or twice a week (2) Three or more times a week (3)**

During the **past month**, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

Options include, please pick one: Not during the past month (0) **Less than once a week (1) Once or twice a week (2) Three or more times a week (3)**

During the **past month**, how much of a problem has it been for you to keep up enthusiasm to get things done?

Options include, please pick one: Not during the past month (0) **Less than once a week (1) Once or twice a week (2) Three or more times a week (3)**