THE HEAG
PAIN MANAGEMENT CENTER, P.A.

Patient Intake – Medical History
(Opioid-Dependent Treatment)

(To be completed by patient)

Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (work) _____ (home) _____ (cell) _____

D.O.B.: _____ Age: _____ SS#: _____

Emergency Contact: _____

Relationship to Patient: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Date of last physical: _____ Have you ever had an EKG? ___ Yes ___ No Date: _____

Past Medical History

Current Medications

What medications are you currently taking? (please list)

Medication	Strength or Dosage	How Often do Take this Medication	Why do you take this Medication	Who Prescribed This Medication

_____

Patient Signature