Matthew M. Keum, M.D., Inc.
Pain Management Clinic

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36060 Euclid Avenue, #101 • Willoughby, OH 44094

Name: _____ Date: _____

Primay Physician: _____ Phone: _____

Who referred you: _____ Phone: _____

Work Status	□ Full time □ Part time □ Unemployed □ Retired □ Disabled Current/Former Occupation:
Are you on disability	□Yes □No If yes, date it started:
With whom do you live?	□ Alone □ Spouse □ Children □ Parents □ Other

COVID INFORMATION

Were you vaccinated: □Yes □No

If yes, which vaccine did you receive: _____

Date of injection #1: _____

Date of injection #2: _____

Did you receive a booster: □Yes □No If so, which one: _____

Date of Booster: _____

FAMILY HISTORY

	RELATION	AGE @ DIAGNOSIS	CURRENT AGE
Back/Neck Problems			
Depression/Mood Disorder			
High Blood Pressure			
Diabetes			
Cancer (list type)			
Other			

Father: Alive: □ Yes □ No Current Age: Age at Death (if applicable): Cause of Death:	Mother Alive: □ Yes □ No Current Age: Age at Death (if applicable): Cause of Death:

SOCIAL HISTORY

Alcohol Use:	☐ NONE	☐ YES	Number of drinks: _____ per day Frequency: Daily Weekly Monthly Rarely Type of Alcohol: _____
Tobacco Use:	☐ NONE	☐ YES ☐ Quit	Smoke, or other:_____ Amount: _____ per day Since: _____ Date quit: _____
Other recreational Drugs:	☐ NONE	☐ YES	What Drugs: _____ Frequency: Daily Weekly Monthly Rarely
Do you drive?	☐YES ☐NO	Do you always wear a seatbelt? ☐ Yes ☐No ☐Sometimes	
Do you exercise?	☐YES ☐NO	If yes, how often: _____	

MEDICAL HISTORY (check all that apply)

☐ Neck Pain	☐ Bleeding Disorder	☐ Macular Degeneration
☐ Back Pain	☐ Stroke	☐ Hearing Loss
☐ Compression Fractures	☐ Seizures	☐ Thyroid Disease(Circle High Low)
☐ Ostoporosis / Osteopenia	☐ Pneumonia	☐ Depression
☐ Herniated Disc (Level _____)	☐ Diabetes (Circle: Type 1 or 2)	☐ Anxiety
☐ Headaches	☐ Hepatitis (Circle: A B C)	☐ Bipolar Disorder
☐ Fibromyalgia	☐ Heart Burn	☐Urinary Tract Infection
☐ Chronic Fatigue Syndrome	☐ Stomach Ulcers	☐ Incontinence
☐ Arthritis	☐ Heart Disease	☐ Kidney Stones
☐ Gout	☐ Angina	☐ Erectile Dysfunction
☐ Cancer (Type_____)	☐ COPD	☐ High Blood Pressure
☐ Prostate Disease	☐ Chronic Wounds	☐ High Cholesterol
☐ Breast Disease	☐ Glaucoma	☐ Blood Clots
☐ Pulmonary Emboli	☐ Congestive Heart Failure	**Allergies: All foods and Medications:**
☐ Coronary Artery Disease	☐ Atrial Fibrillation	
☐ MI / Heart Attacks	☐ Other:	

SURGICAL HISTORY

☐ None	☐ Kyphoplasty	☐ Pacemaker
☐ Cervical Surgery	☐ Vertebroplasty	☐ Heart Valve Replacement
Procedure_____	☐ Spinal Surgery	☐ Gall Bladder
Surgeon_____	☐ Orthopedic Joint	☐ Hysterectomy
Year_____	☐ Cataracts	☐ C-Section
☐ Lumbar Surgery	☐ Lasik	☐ Bowel / Stomach Resection
Procedure_____	☐ Endoscopy	☐ Hernia Repair
Surgeon_____	☐ Colonoscopy	☐ Foot Surgery
Year_____	☐ Tonsillectomy	☐ Prostate Surgery
☐ Thoracic Surgery	☐ Adenoidectomy	☐ Other:
Procedure_____	☐ Thyroidectomy	
Surgeon_____	☐ Coronary Bypass	
Year_____	☐ Cardiac Bypass	