GULF COAST
PAIN INSTITUTE
"RELIEVING PAIN, RESTORING FUNCTION, RENEWING HOPE"

PATIENT HISTORY INDEX (ORT)

Please complete as directed. This will help your Doctor in the evaluation process

Today's Date: _____
Patient Name: _____ DOB: _____

Mark each box that applies

1. **Family History of Substance Abuse:**
   - Alcohol..... ❑ Yes ❑ No
   - Illegal Drugs..... ❑ Yes ❑ No
   - Prescriptions Drugs..... ❑ Yes ❑ No
2. **Personal History of Substance Abuse:**
   - Alcohol..... ❑ Yes ❑ No
   - Illegal Drugs..... ❑ Yes ❑ No
   - Prescriptions Drugs..... ❑ Yes ❑ No
3. **Age (mark box if between 16-45)** ..... ❑ Yes ❑ No
4. **History of Childhood Trauma**..... ❑ Yes ❑ No
   (Physical or Sexual Abuse)
5. **Psychological Disease:**
   - Attention Deficit Disorder ..... ❑ Yes ❑ No
   - Obsessive-Compulsive Disorder..... ❑ Yes ❑ No
   - Bipolar Disorder..... ❑ Yes ❑ No
   - Schizophrenia..... ❑ Yes ❑ No
   - Depression..... ❑ Yes ❑ No

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1. Do you have sleep apnea? ..... ❑ Yes ❑ No
2. Do you have COPD? ..... ❑ Yes ❑ No
3. Do you drink alcohol daily? ..... ❑ Yes ❑ No
4. Do you currently smoke two or more packs per day? ..... ❑ Yes ❑ No
5. Does your family and care givers understand your pain? ..... ❑ Yes ❑ No

   If No, explain: _____
   _____
   _____
   _____