PAIN CARE
BOISE

CHEST PAIN QUESTIONNAIRE

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

Office Use:

Where is your pain located?
Date of injury ~or~ When did your pain start / /
How did your pain problem start?

Please mark "YES" or "NO" for each of the following conditions:	
☐ Y ☐ N	Have you had any prior surgery for this or similar type pain problem? If yes, when? / /
☐ Y ☐ N	Have you had a prior heart attack?
☐ Y ☐ N	Have you had prior angina?
☐ Y ☐ N	Have you had prior cardiac problems?
☐ Y ☐ N	Have you had a prior cardiac work up?

☐ Y ☐ N	Does your chest pain increase with exertion? (for example a fast walk or walking upstairs)
☐ Y ☐ N	Does your chest pain increase with inspiration?
☐ Y ☐ N	Does your chest pain increase after eating?
☐ Y ☐ N	Does your chest pain increase when lying down?

Office Use: