Follow Up

Date of visit: ____________________________

Name: ________________________________

Date of birth: ___________________________

Pain Description

Where is Your **worst** pain today?

____

How would you describe your pain? ☐Sharp ☐Dull ☐Aching ☐Burning ☐Shooting ☐Stabbing ☐Throbbing ☐Numb ☐Tingling ☐ Pressure ☐ Nagging

☐ Crampy Other:_____________________

Is Your Pain ☐ constant ☐ Intermittent

How Often Do You have this pain?

☐Daily ☐2-3days/wk ☐ 4-5 days/wk

Does the pain radiate? Where? _______________

Is this pain new? ☐ Yes ☐ No

Since your last office visit, has the pain

☐ Stayed the same ☐ Increased ☐ Decreased

Pain is worse with: (circle all that apply)

☐ Standing ☐ sitting ☐ Walking ☐ Exercise

☐ Bending ☐ Lifting ☐Driving ☐UsingComputer

Have you developed any new symptom:

☐ Bladder incontinence

☐ Bowel incontinence

☐ Difficulty walking

☐ Tingling Where: ______________________

☐ Numbness Where: ______________________

☐ Weakness Where: ______________________

Did you have a procedure? ☐ Yes ☐ No

Did it help? ☐ Yes ☐ No Please explain:

____

Percent of improvement in pain (0-100%) _______

Any problems with procedure? _______________

Are you getting improvement of pain from your current medications? ☐ Yes ☐ No

Percent of improvement in pain (0-100%) _______

Are you able to perform the following tasks with medication: ☐ Activity of Daily Living ☐ Walking ☐ Exercise ☐ Sleep ☐ Working

Mark medication side effects, if any:

☐ Drowsiness ☐ Itching ☐ Dry mouth

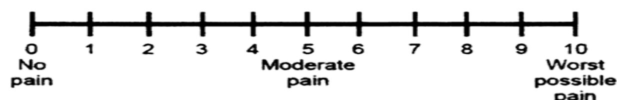
☐ Nausea ☐ Constipation ☐ No side effects

Does your pain interfere with your:

☐ Walking ☐ Work ☐ Hobbies ☐ Sleep

☐ Housework Activity of Daily Living

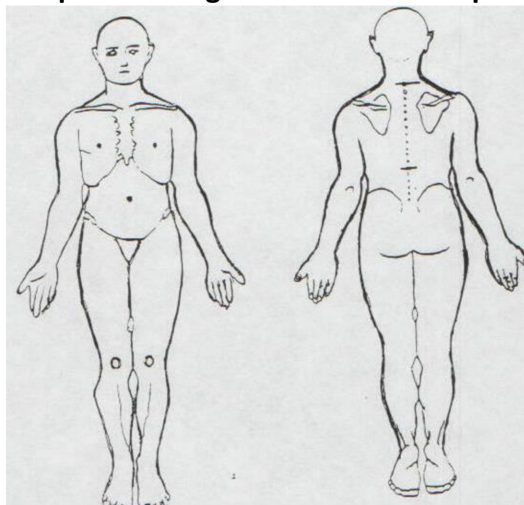
PAIN SCALE Over the last month, rate your pain:



Currently: ____ Worst: _____ Least Level: ____

With Medication ___________

Mark pain on diagram. Mark worst spot with an X.



Medical History – Changes since your last office visit

New Surgeries / Hospitalizations ☐ Yes ☐ No New medications ☐ Yes ☐ No

New medical problems ☐ Yes ☐ No New imaging studies ☐ Yes ☐ No

If yes, elaborate: ____

Currently prescribed a blood thinner. ☐ Yes ☐ No Medication:_____________ Prescriber: ____________________

Allergies: ☐ No known allergies ☐ Latex ☐Iodine ☐ Medications (list all) ________________________________

Review of Systems (Please Check All That Apply)

General

☐ Weight Gain

☐ Weight Loss

☐ Tiredness/Fatigue

☐ Fever ☐ Chills

Allergy/Immunology

☐ Rash

☐ Seasonal allergy

☐ Nasal Congestion

HEENT

☐ Decrease Hearing

☐ Dry Mouth ☐ Ear Pain

Endocrine

☐ Cold/Heat Intolerance

☐ Excessive Sweating

Respiratory

☐ Difficulty Breathing

☐ Wheezing

☐ Shortness of Breath

Cardiovascular

☐ Palpitation

☐ Chest Pain

☐ Swelling of Hands/Feet

Gastrointestinal

☐ Nausea ☐ Vomiting

☐ Diarrhea ☐ Constipation

☐ Abdominal Pain

☐ Incontinence of Stool

Genitourinary

☐ Pelvic Pain

☐ Incontinence of Urine

☐ Difficulty with Urination

☐ Painful Urination

Musculoskeletal

☐ Neck Pain

☐ Back Pain

☐ Joint Pain

☐ Muscle Cramps

☐ Muscle Pain

☐ Swollen Joint

Neurological

☐ Headaches ☐ Dizziness

☐ Arm Weakness

☐ Leg Weakness

☐ Arm/Leg Numbness/Tingling

☐ Balance Difficulty

Psychiatric

☐ Depression

☐ Suicidal Ideation

☐ Anxiety

☐ Insomnia

Hematology

☐ Abnormal bleeding

☐Bruise easily

Peripheral Vascular

☐ Blood clots

☐ Cold Extremities

Office Use Only:

Risk level: Low Mod High

Ht: _________ Wt: _________ Pulse: _________

O2: _________ BP: _________ / _________

UA POC/Oral Swab: Not required Done

BZO BAR COC THC MET OPI MTD TCA OXY PCP AMP

Patient signature: ____ Date: ________________________________