Follow Up

Date of visit: ____________________________

Name: ________________________________

Date of birth: ___________________________

Pain Description

Where is the location of your worst pain today?

____

Is this pain new? ☐ Yes ☐ No

Since your last office visit, has the pain

☐ Stayed the same ☐ Increased ☐ Decreased

How would you describe your pain?

☐Sharp ☐Dull ☐Aching ☐Burning
☐Shooting ☐Stabbing ☐Throbbing Other:________
____

Is Your Pain ☐ constant ☐ Intermittent

How often do you have flare-ups of pain?

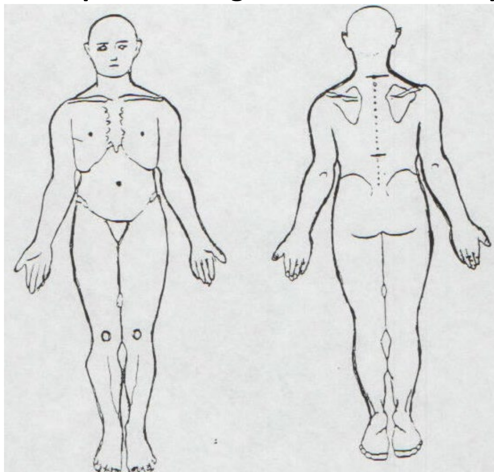
☐Daily ☐ every 2-3 days ☐ every 4-5 days

PAIN SCALE Over the last month, rate your pain 1-10:

Currently: ____ **Worst:** _____ **Least Level:** ____

With Medication ___________

Mark pain on diagram. Mark worst spot with a X



Does the pain radiate? Where?

____

Do you feel any:

☐ Tingling Where: ______________________

☐ Numbness Where: ______________________

☐ Weakness Where: ______________________

Pain is worse with: (circle all that apply)

☐ Standing ☐ Walking ☐ Exercise

☐ Sitting

☐ Bending ☐Driving ☐Using Computer
☐Lifting

Did you have a procedure? ☐ **Yes** ☐ **No**

Did it help? ☐ Yes ☐ No Please explain:

____

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

Any problems with the procedure?_____________

Are you getting relief from pain with your current medications? ☐ **Yes** ☐ **No**

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

Mark medication side effects, if any:

☐ Drowsiness ☐ Itching ☐ Dry mouth
☐ Nausea ☐ Constipation ☐ No side effect

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

Does your pain interfere with your:

☐ Walking ☐ Work ☐ Hobbies ☐ Sleep

☐ Housework ☐Activity of Daily Living

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: ____________________
New allergies and side effects: ☐ Latex ☐Iodine ☐ Medication:
____
Did your pharmacy change? ☐ No ☐ Yes If yes, name of pharmacy: ________________________________

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 SOAPP-R score: _________
Ht: _________ Wt: _________ Temp ______________
O2: _________ BP: _________ / _________ Pulse: ____________
Drug Screen: UDS POC/Oral Swab: Not required Done
Patient last took opioid medication:__________________________
Previous UDS: ☐ Consistent ☐Inconsistent
BZO BAR COC THC MET OPI/MOP MTD TCA OXY PCP AMP BUP NEGATIVE
Is there any change on pharmacy? ☐ Yes ☐ No