SOUTHERN INTERVENTIONAL PAIN CENTER FOLLOW-UP FORM

Patient Name						DOB:			Date:		
Since your LAST VISIT have you ha	d any NE	W INJU	RIES or N	EW AREA	\S of pain	?					
Where are your ONGOING SEVER radiating pain)	E areas o	f pain?	Mark an	d draw b	elow (dra	w 'X' on	most seve	ere areas	of pain a	nd use ar	rows for
Since your last office visit, your pa	in is:	CONS	TANT	OR 🗆	COMES	and GO	ES				
Since your last office visit, your pa	in is:	□ ВЕ	TTER			ΊE		□ WO	ORSE		
Describe your pain: ☐ Ache ☐ Bu	rn 🗆 Cra	mp □ D	oull 🗆 Sh	arp 🗆 St	ab □Tea	ar 🗆 Thr	rob 🗆 Nu	mbness	☐ Pins/N	leedles/T	ingling
Associated symptoms: none numbness weakness fevers chills			□ loss □ loss □ urin	ight loss s of bladd s of bowe nary reter s of balan	ntion	ol			stiffness swelling/r sleep prob other:	lems	
Rate your pain level NOW :	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	□ 7	□ 8	□ 9	□ 10
WORST pain level in past week:	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6	□ 7	□ 8	□ 9	□ 10
LOWEST pain level in past week:	□ 0	□1	□ 2	□ 3	□ 4	□ 5	□ 6	□ 7	□ 8	□ 9	□ 10
How much has your PAIN IMPRO	/ED? □ ()% 🗆 10	0% 🗆 20	% □ 30%	% □ 40%	□ 50%	60%	□ 70%	□ 80%	□ 90%	□ 100%
How much has your FUNCTION IN	1PROVED)? □ 0%	□ 10%	□ 20%	□ 30% □	40% 🗆	50% 🗆 6	0% 🗆 70	0% 🗆 809	% □ 90%	□ 100%
Any SIDE FEFECTS caused by your	pain me	dications	;?								

□ Lethargy/sedation □ Hearing loss □ Fainting □ Short of breath □ Nausea/v □ Fevers □ Snoring □ Palpitations □ Sleep apnea □ Constipat ■ GU Neuro Psych Heme/Lymph Skin/A □ loss of urine control □ Seizures □ Depression □ Swollen glands □ rashes □ Urinary retention □ Dizziness □ Anxiety □ Easy bruising □ itching	at:		-	on from another doctor?		
e your LAST office visit, have you taken any illicit drugs including marijuana, hashish, cocaine, crack, methamphetam hetamine, PCP, ketamine, GHB, heroin, ecstasy, mushrooms, opium, or bath salts?	r LAST office visit , have yo	ou taken extra dose	s of pain medicine or tal	ken someone else's pain m	edicine? 🗆 Yes 🗆 N	
e your LAST office visit, have you had any new medical problems, surgeries, ER visit or hospitalizations? Yes S Ist changes Yes Ist changes Yes Yes Ist changes Yes Ye	r LAST office visit , have yo	ou started using or i	ncreased your use of alc	ohol? ☐ Yes ☐ No		
Symptoms you are CURRENTLY having only: Constitutional	· · · · · · · · · · · · · · · · · · ·				nethamphetamine,	
Medication Changes Since Last Visit Medication Dosage # You Take Daily Prescribing Doctor Symptoms you are CURRENTLY having only: Constitutional ENT CV Resp Ghard Nausea/Versers Shorting Palpitations Sleep apnea Constipat Weight loss Palpitations Seizures Depression Sof urine control Dizziness Anxiety Seasy bruising allergic response Symptom and I have provided the correct information above. I also un	r LAST office visit , have yo	ou had any new med	dical problems, surgeries	s, ER visit or hospitalizations	s? □Yes □N	
Medication Changes Since Last Visit Medication Dosage # You Take Daily Prescribing Doctor Symptoms you are CURRENTLY having only: Constitutional ENT CV Resp Short of breath Short of breath Sleep apnea Constipat Weight loss Palpitations Sleep apnea Constipat GU Neuro Psych Heme/Lymph Skin/A Short of Dizziness Depression Swollen glands rashes Anxiety Easy bruising allergic results. By signing below, I agree that I have completed this entire form and I have provided the correct information above. I also un	changes					
Medication Dosage # You Take Daily Prescribing Doctor Symptoms you are CURRENTLY having only: Constitutional ENT CV Resp G Nausea/v Short of breath Nausea/v Short loss Palpitations Sleep apnea Constipat GU Neuro Psych Heme/Lymph Skin/A Obstract Seizures Depression Swollen glands ashes itching Insomnia allergic results. By signing below, I agree that I have completed this entire form and I have provided the correct information above. I also un	r LAST office visit , has you	ur stress increased?	☐ Yes ☐ No.	If, yes then why:		
Medication Dosage # You Take Daily Prescribing Doctor Symptoms you are CURRENTLY having only: Constitutional ENT CV Resp G Nausea/v Short of breath Nausea/v Short loss Palpitations Sleep apnea Constipat GU Neuro Psych Heme/Lymph Skin/A Obstract Seizures Depression Swollen glands ashes itching Insomnia allergic results. By signing below, I agree that I have completed this entire form and I have provided the correct information above. I also un						
Symptoms you are CURRENTLY having only: Constitutional		Medic	ation Changes Since Las	t Visit		
Constitutional ENT CV Resp G Lethargy/sedation Hearing loss Fainting Short of breath Nausea/v Fevers Snoring Palpitations Sleep apnea Constipat Weight loss Weight loss Weight loss Sleep apnea Constipat Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output O	Medication	Dosage	# You Take Daily	Prescribing Docto	or	
Constitutional ENT CV Resp G Lethargy/sedation Hearing loss Fainting Short of breath Nausea/v Fevers Snoring Palpitations Sleep apnea Constipat Weight loss Weight loss Weight loss Sleep apnea Constipat Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output Output O					_	
Constitutional ENT CV Resp G					_	
Constitutional ENT CV Resp G					_	
Constitutional ENT CV Resp G					_	
Lethargy/sedation		Sympt	toms you are CURRENTL	Y having only:		
Fevers	Constitutional	ENT	CV	Resp	GI	
Weight loss		=	_		☐ Nausea/vomitin	
□ loss of urine control □ Seizures □ Depression □ Swollen glands □ itching □ itching □ allergic re By signing below, I agree that I have completed this entire form and I have provided the correct information above. I also un		□ Snoring	☐ Palpitations	□ Sieep apnea	☐ Constipation	
□ loss of urine control □ Seizures □ Depression □ Swollen glands □ itching □ itching □ allergic re By signing below, I agree that I have completed this entire form and I have provided the correct information above. I also un	GU	Neuro	Psych	Heme/Lymph	Skin/Allergy	
Urinary retention Dizziness Anxiety Easy bruising itching allergic re			-			
By signing below, I agree that I have completed this entire form and I have provided the correct information above. I also un	☐ Urinary retention	☐ Dizziness	☐ Anxiety	☐ Easy bruising	□ itching	
			□ Insomnia		☐ allergic reaction	
			'	<u>'</u>	•	
			s entire form and I have pro	ovided the correct information	above. I also understar	
Signature of Patient, Guardian or Patient Representative Date						