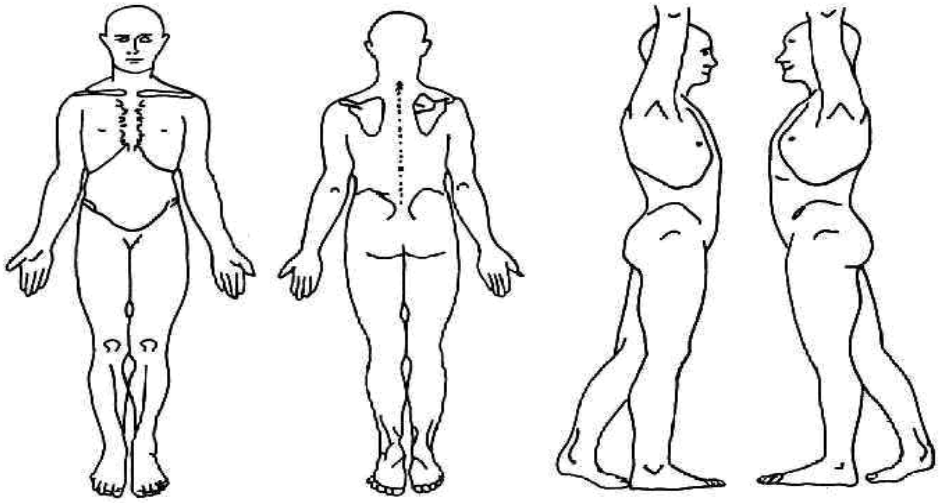
SOUTHERN INTERVENTIONAL PAIN CENTER FOLLOW-UP FORM

Patient Name_____ **DOB:**_____ **Date:** _____

Since your LAST VISIT have you had any **NEW INJURIES** or **NEW AREAS** of pain? _____

Where are your **ONGOING SEVERE** areas of pain? Mark and draw below (draw 'X' on most severe areas of pain and use arrows for radiating pain)



Since your last office visit, your pain is: ☐ CONSTANT **OR** ☐ COMES and GOES

Since your last office visit, your pain is: ☐ BETTER ☐ SAME ☐ WORSE

Describe your pain: ☐ Ache ☐ Burn ☐ Cramp ☐ Dull ☐ Sharp ☐ Stab ☐ Tear ☐ Throb ☐ Numbness ☐ Pins/Needles/Tingling

Associated symptoms:

- ☐ none
- ☐ numbness
- ☐ weakness
- ☐ fevers
- ☐ chills
- ☐ weight loss
- ☐ loss of bladder control
- ☐ loss of bowel control
- ☐ urinary retention
- ☐ loss of balance
- ☐ stiffness
- ☐ swelling/redness
- ☐ sleep problems
- ☐ other:_____

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 IMPROVED**? ☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

How much has your **FUNCTION IMPROVED**? ☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Any **SIDE EFFECTS** caused by your pain medications? _____

Since your **LAST office visit**, have you received any **injections** or **pain medication** from another doctor? ☐ Yes ☐ No

If yes, what: _____

Since your **LAST office visit**, have you **taken extra doses** of pain medicine or **taken someone else's** pain medicine? ☐ Yes ☐ No

Since your **LAST office visit**, have you started using or increased your use of **alcohol**? ☐ Yes ☐ No

Since your **LAST office visit**, have you taken any **illicit drugs** including marijuana, hashish, cocaine, crack, methamphetamine, amphetamine, PCP, ketamine, GHB, heroin, ecstasy, mushrooms, opium, or bath salts? ☐ Yes ☐ No

Since your **LAST office visit**, have you had any new medical problems, surgeries, ER visit or hospitalizations? ☐ Yes ☐ No

If, yes list changes _____

Since your **LAST office visit**, has your stress increased? ☐ Yes ☐ No. If, yes then why: _____

Medication Changes Since Last Visit

Medication	Dosage	# You Take Daily	Prescribing Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Symptoms you are CURRENTLY having only:

Constitutional	**ENT**	**CV**	**Resp**	**GI**
☐ Lethargy/sedation ☐ Fevers ☐ Weight loss	☐ Hearing loss ☐ Snoring	☐ Fainting ☐ Palpitations	☐ Short of breath ☐ Sleep apnea	☐ Nausea/vomiting ☐ Constipation
GU	**Neuro**	**Psych**	**Heme/Lymph**	**Skin/Allergy**
☐ loss of urine control ☐ Urinary retention	☐ Seizures ☐ Dizziness	☐ Depression ☐ Anxiety ☐ Insomnia	☐ Swollen glands ☐ Easy bruising	☐ rashes ☐ itching ☐ allergic reaction

By signing below, I agree that I have completed this entire form and I have provided the correct information above. I also understand that I may receive a copy for my records.

_____ _____

Signature of Patient, Guardian or Patient Representative Date