

EASTWIND PAIN CONSULTANTS FOLLOW UP QUESTIONNAIRE

Name: _____

Date: _____

Home Phone:	Pharmacy Phone:
Allergies: (Write NKDA if you don't know of any allergies)	

Are you working?(circle one) **YES** **NO** Who is your insurance provider? _____

On a scale out of 10, (10 being the worst) how much pain are you in today?

1 2 3 4 5 6 7 8 9 10

Where are you feeling your pain? _____

What questions would you like to ask the doctor today? _____ Addressed By:

Please list your **current medications**, include all vitamins and herbs you may be using (Use back if necessary)

Do you need any prescription refills today? If yes please list medication and dosage. **YES** **NO**

What is your goal in regards to pain management? _____

Have there been any changes in your medications? If yes, then list them. **YES** **NO**

Have you had any of the following since your last visit? If yes, please explain.

Headache Dizziness Blurred vision	
Ringing in the ears	
Dry mouth	
Chest pain Palpitations	
Wheezing Shortness of breath	
Weight gain or loss	
Nausea Vomiting	
Constipation Diarrhea	
Difficulty with urination	
Dry skin Rash Bruising Itching	
Increased thoughts of suicide or harming your self	
Sexual dysfunction	
Increased irritability or loss of temper	
Felt more depressed or uninterested	
Do you smoke? If yes how many packs per day	
Change in sleep or difficulty sleeping	
Numbness Tingling Burning	

Functionality: Circle what tasks below you can complete with or without pain:

- Prepare meals – able to do light housekeeping – wash dishes – sweep – vacuum – grocery shop
- Social – gather with friends – worship services – children or grandchildren’s events- dress self – bathe/shower – drive a car

Clinic Follow Up

Name: _____ DOB: _____ Date: _____

Employment status full-time part-time disability other _____

Referring Physician: _____ Chief Complaint: _____

History of Present Illness: _____

B/P: _____/_____ P: _____ HT: _____ WT: _____ NPI: _____/10

Reviewed (4) Onset Duration Location Quality Timing
 Exacerbating/Relieving factors Radiation Associated SX

PMHx No Change

PSHx No Change _____

Medication Assessment (listed on other side)

ROS reviewed with Patient: _____ (2)

ADLS/SH: _____ Quality of family life/ activities _____

Adverse S/E No Yes (details) _____

Abberrent S/S No Yes (details) _____

Physical Exam (12): (x is nl, circled is abnormal, comments below) AOX3 Gait: _____ General

Appearance: _____

RESP: Auscultate Percuss CV: Auscultate

Abdomen: _____

Skin: Inspection skin/subQ Palpation skin/subQ Full undressed skin exam
Neuro: Cranial nerve Reflexes Sensation
Psych: Judgement/insight Orientationx3 Memory Mood & affect
Musc: Gait & station Digits & nails Head/neck rubs/pelvis
 RUE LUE RLE LLE
Inspect/palp: ROM Stability Strength/tone Spine

Straight Leg Raise	L + -	R + -
Spuring	L + -	R + -
Faberes	L + -	R + -
Patricks	L + -	R + -
DTR (see figure 1)	L + -	R + -

Neurologic _____

PE comments: _____

ROM Spine () cx () lx Flex: _____ Ext: _____

Impression: _____

Plan: _____

Signature: _____ M.D./CNP

Risk/Benefits communicated with patient

Patient care discussed with Dr. Choung/ Dr. Figg