**ADVANCED INTERVENTIONAL PAIN CONSULTANTS Follow Up Visit**

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth** \_\_\_\_\_\_\_\_\_\_ **Age** \_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_

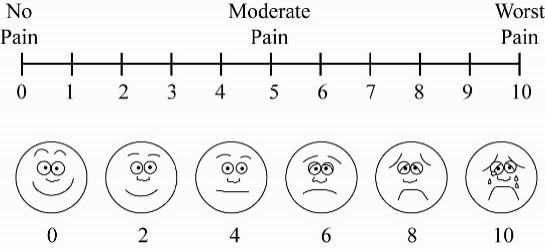
**PRIMARY CARE DOCTOR** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **REFERRING PHYSICIAN** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

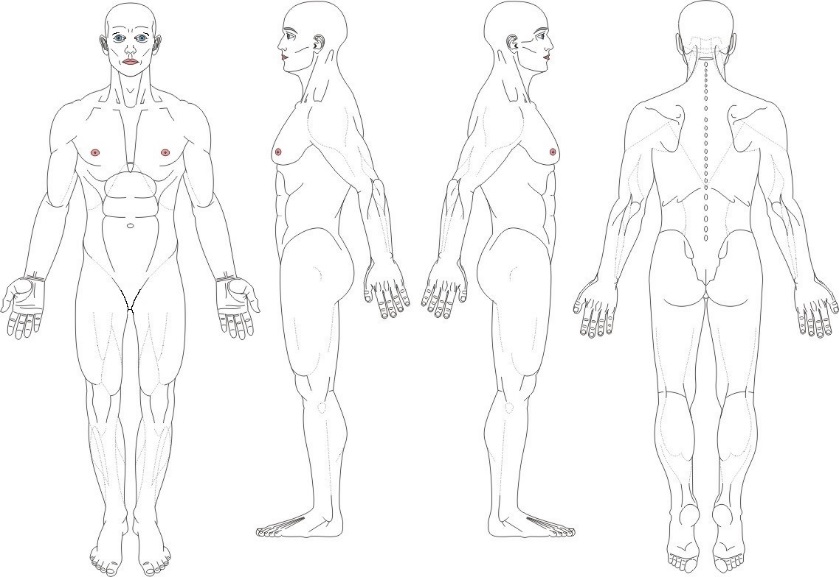
**WHAT IS YOUR MAIN PAIN COMPLAINT TODAY?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY OF PRESENT ILLNESS**

**How are you doing since your last visit?** \_\_\_ Improved \_\_\_ No change \_\_\_ Worse Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Where** is your pain located? Draw **How intense** is your pain? Circle the lowest and highest

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How do you best **describe** your pain?

\_\_\_Dull \_\_\_Electrical \_\_\_Stabbing \_\_\_Burning

\_\_\_Aching \_\_\_Throbbing \_\_\_Shock-like \_\_\_Sharp

What is the **pattern** of your pain?

\_\_\_ Constant \_\_\_ Intermittent

\_\_\_ Mornings \_\_\_ Afternoons \_\_\_ Nights

Does the pain **radiate** to other areas? \_\_\_Yes \_\_\_No

If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any **associated symptoms?** \_\_\_ Numbness \_\_\_ Weakness \_\_\_ Muscle spasms \_\_\_ Tingling

Has the **TREATMENT** you are receiving improved any of the following aspects of your life?

**Activities of daily living** \_\_\_ Yes \_\_\_ No **Relations with people** \_\_\_ Yes \_\_\_ No

**Ability to work** \_\_\_ Yes \_\_\_ No **Sleeping/rest** \_\_\_ Yes \_\_\_ No

**Family life** \_\_\_ Yes \_\_\_ No **Depression/anxiety** \_\_\_ Yes \_\_\_ No

Overall, has the treatment you are receiving made a **positive change** in your condition? \_\_\_ Yes \_\_\_ No

Have the medications we prescribed caused any of the following **SIDE EFFECTS**? (Circle all that apply)

Nausea Vomiting Itchiness Constipation Drowsiness Sweating Loss of libido Weight gain Swelling

List all **OTHER MEDICATIONS** you are currently taking. Include pain creams. Include dose (mg) and how many pills you take per day

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you **ALLERGIC** or sensitive to any medications? \_\_\_ No \_\_\_ Yes List \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any **blood thinners**? \_\_\_ No \_\_\_ Yes

**OPIOID ATTESTATION**

\_\_\_ I have used all medications prescribed to me exactly as prescribed.

\_\_\_ I have reported all side effects to my physician.

\_\_\_ I have not sold, given to someone else, or otherwise transferred my medications to anyone.

\_\_\_ I have safeguarded my medications from theft.

\_\_\_ I have not received, accepted, taken, or otherwise used any other opioid medications (narcotics) from any other source,

including from other physicians.

\_\_\_ I have not received, accepted, taken, or otherwise used any illegal drugs.

\_\_\_ I have not used alcohol while taking my opioid medications (narcotics).

I attest and certify that all of the following statements are true and factual

**Patient‘s Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY** Has your medical history changed since your last visit, including ER visits and hospitalizations? \_\_\_No \_\_\_Yes

Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SURGICAL HISTORY** Have you had surgery since your last visit? \_\_\_ No \_\_\_ Yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you doing **PHYSICAL THERAPY? \_\_\_** No \_\_\_ Yes

Are you under **psychiatric care** or **receiving psychological counseling**? \_\_\_ No \_\_\_ Yes

**REVIEW OF SYSTEMS Circle all that apply** \_\_\_\_ No new problems

**1. General**  Weight gain or loss, unexplained hair loss, fever or chills, low energy, too sleepy, too tired

**2. ENT**  Eye pain, vision problems (blurred vision, loss of vision), hearing loss, swollen glands in neck, sore throat/pain when swallowing, dental problems

**3. Cardiovascular**  Chest pain (sharp, crushing, or heaviness), heart racing (palpitations), fainting spells, shortness of breath, swelling of legs (edema)

**4. Respiratory** Shortness of breath, cough/coughing up blood

**5. Gastrointestinal**  Increased appetite,decreased appetite, stomach pain, nausea/vomiting, diarrhea, constipation

**6. Genitourinary**   Pain when passing water (urination), blood in urine, urinating more than usual (day and/or night), bladder Infection,pain during sex, changes in sex drive (libido)

**7. Musculoskeletal** Limited motion of arms or leg, joint pain, swelling/redness, numbness, tingling, or weakness in arms or legs

**8. Neurological**  Arm/leg weakness,new headaches, problems with memory or speech, tremors

**9. Psychiatric**  Sadness, stress, anxious, seeing or hearing things, suicidal thoughts, feeling down, insomnia

**10. Endocrine**  Weight gain/loss,thirsty all the time, cannot stand temperature changes (heat/cold)

**11. Lymph**  Swollen glands (armpits or groin)

**12. Skin** Rash (palm of hands, sole of feet), changes in skin, sores or rash on skin

**13. Allergies**  Hives/skin rashes, allergic reaction to foods

I attest that all of the information I have provided is accurate and factual, and I can provide supporting information.

**Patient‘s Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_