GENESIS MEDICAL CENTER –PAIN FOLLOW UP VISIT

Instructions: Please fill completely. Put N/A if it does not apply to you.

Patient Name_____**Date**_____

Patient Phone_____**E-mail**_____

Change of Address_____

1. **Have you been seen by any other physician since your last visit to Superior Medical Center? YES or NO**
2. **Did you receive any controlled substances from a physician/other source since your last visit? YES or NO**

   Medication name _____**Dosage**_____**Times per day**_____
3. **Have you been to the ER since your last visit? YES or NO**
4. **Please list any changes to your current pain medications and the doctors that prescribe them**

   Name **Dosage** **Times per day** **Prescribing Doctor**

   _____

   _____
5. **What is your current pain on the scale below with the medication prescribed?**

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild			Moderate Pain		Severe Pain	Very severe pain		Worst Pain

6. **Have your symptoms been helped Explain.**

   _____
7. **Please check any conditions you have experienced since your last appointment:**

□ Chills	□ Night Sweats	□ Fever	□ Easy Bleeding	□ Rash
□ Bruising	□Hearing loss or taste	□ Dizziness	□ Shortness of Breath	□ Wheezing
□ Cough	□ Chest Pain	□ Feet swelling	□ Palpitations	□ Nausea
□ Diarrhea	□ Indigestion	□ Abdominal Pain	□ Frequent urination	□ Constipation
□ Muscle cramps	□ Joint pain/swelling	□ Morning stiffness	□ Numbness	□ Tingling
□ Lack of sleep	□ Crying spells	□ Convulsion	□ Headache	□ Anxiety
□ Depression	□ Other, Explain:			

8. **Check below if your pain has affected any of the following activities during the past month:**

□ Mood	□ Walking	□ Sleep	□ Relationships with others	□ Concentration
□ Sex	□ Work	□ Appetite	□ Enjoyment of Life	□ Other

9. **Please list any changes from the direction given to you by the doctor:**

   _____

10. What does the pain feel like? Check those words that describe your pain.

□ Aching	□ Throbbing	□ Shooting	□ Stabbing	□ Gnawing
□ Pricking	□ Sharp	□ Tender	□ Burning	□ Exhausting
□ Tiring	□ Penetrating	□ Nagging	□ Numb	□ Miserable
□ Unbearable	□ Dull	□ Radiating	□ Squeezing	□ Cramping
□ Deep	□ Other, Explain:			

11. Place an (X) by each that applies to you

Physical Symptoms*

□ Palpations or accelerated heart	□ Shortness of breath or smothering sensation	□ Sweating or cold, clammy hands
□ Dry Mouth	□ Dizziness or lightheadedness	□ Nausea, diarrhea, or other abdominal distress
□ Flushes (hot flashes) or chills	□ Frequent urination	□ Trouble swallowing or lump in throat

Tension Symptoms*

□ Restlessness	□ Trembling, twitching, or shaky	□ Muscle tension, aches or soreness	□ Easily fatigue

Emotional Symptoms*

□ Excessive worrying	□ Difficulty concentrating or mind going blank because of anxiety	□ Feeling keyed or on edge
□ Trouble falling asleep or staying asleep	□ Irritability	

12. Note: It is important to know that most pain CAN be relieved. Your doctor will work with you to find the treatment that may be best for your pain. The key to effective pain control is to take the ***RIGHT AMOUNT***, of the ***RIGHT MEDICINE***, at the ***RIGHT TIME***. You should take your pain medicine on a regular schedule, as your doctor, nurse or pharmacist tells you. Don't wait until the pain becomes sever. Pain is easier to control when it is mild than when it has reached full force. If your pain medicine wears off too soon, is not relieving the pain, or causes problems with side effects, you should call your doctor because you may need to have your treatment plan changed.

13. Female Patient

Last date of menstruation _____

Are you pregnant ☐Yes ☐No

If yes, date of expected delivery_____

14. **Comments: Write down any questions or information you need to share with your doctor, nurse or pharmacist about your pain.**