MARYLAND PAIN SPECIALISTS, P.A.
410-825-6945

FOLLOW-UP VISIT

Name_____Date of Birth_____Date_____

Patient Signature _____

Reason for today's visit: _____

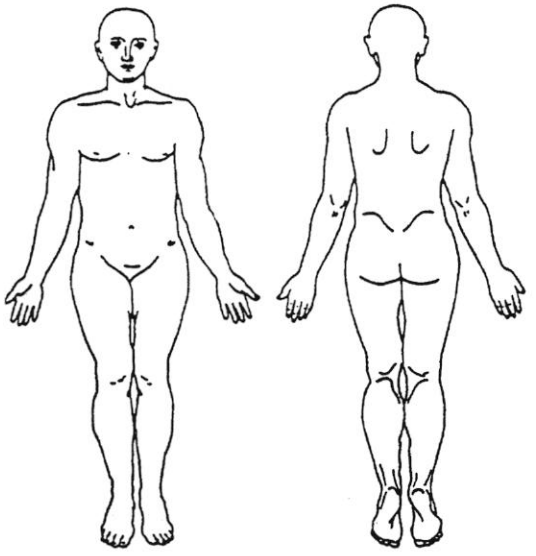
Has your pain ( ) improved, ( ) worsened, or ( ) stayed the same since your last visit/procedure?

How satisfied are you with your pain control? (circle one): completely satisfied, very satisfied, quite satisfied, no change, dissatisfied, very dissatisfied, completely dissatisfied?

Please list any new medical conditions or changes in your mental or physical health status since your last visit: _____

Have you had a problem with alcohol or drug addiction since your last visit? _____

On the diagram (to the right), shade in the areas where you feel pain. Put an **'X'** on the area that hurts the most.



Circle the **word(s)** that best describe your pain:

Throbbing	Shooting	Stabbing
Sharp	Cramping	Gnawing
Hot/burning	Aching	Heavy
Tender	Splitting	Sickening
Tiring/Exhausting		Fearful
Punishing/Cruel		

Please rate your pain by circling the **one number** that best describes your pain on the **average**.

0 1 2 3 4 5 6 7 8 9 10

No Pain — **Pain as bad as you can imagine**

Is your pain ( ) constant or ( ) intermittent (on and off)?

What makes your pain worse? _____

What makes your pain better? _____

Do you smoke? ( ) Yes ( ) No Have you ever smoked? ( ) Yes ( ) No

Are you having any of the following: ( ) constipation, ( ) nausea, ( ) decreased libido, ( ) heartburn, ( ) endocrine imbalance, ( ) fractures _____

MARYLAND PAIN SPECIALISTS, P.A.
410-825-6945

Name_____Date of Birth_____Date_____

Circle the **number** that describes how during the past 24 hours pain has interfered with each of the following functions.

A. General activity

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere **Completely Interferes**

B. Mood

0 1 2 3 4 5 6 7 8 9 10

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10

D. Normal Work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10

E. Relationships with other people

0 1 2 3 4 5 6 7 8 9 10

F. Sleep

0 1 2 3 4 5 6 7 8 9 10

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

What **treatments** are you receiving for your pain? _____

_____

What treatments have you tried and **failed**? _____

Describe any side effects from your pain medications or injections: _____

Do your **pain medications allow** you to ( ) perform activities of daily living (dress, groom, etc.), ( ) walk, ( ) do leisure activities, ( ) work, or ( ) exercise? Please check all that apply.

In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the **one percentage** that most shows how much **relief** you have received.

0% 10 % 20% 30% 40% 50% 60% 70% 80% 90% 100%

No Relief **Complete Relief**

Over the past 2 weeks have you been bothered by these problems?	**Not at all**	**Several days**	**More days than not**	**Nearly every day**
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3

MARYLAND PAIN SPECIALISTS, P.A.
410-825-6945

Name_____Date of Birth_____Date_____

REVIEW OF SYSTEMS

PLEASE **CIRCLE** ANY OF THE FOLLOWING YOU HAVE EXPERIENCED IN THE LAST MONTH:

Constitutional: chills, fatigue, fever, unintentional weight loss

Respiratory: cough, wheezing, labored/difficult breathing, sleep apnea

Musculoskeletal: joint stiffness, joint pain, muscle tenderness, history of fractures

Neurologic: confusion, dizziness, sedation, headaches, memory loss, numbness/tingling, seizures, muscular weakness

Psychiatric: crying spells, feeling stressed, loss of interest in pleasurable activities, mood swings, poor concentration, recreational drug use, drug seeking or craving, sleep disturbance

Physician/Provider Signature _____