MIDLANDS orthopaedics & NEUROSURGERY

Pain Management Follow-Up Form

Reason for your visit today?

_____

CURRENT Height:_____ **Weight**:_____

PAIN SCORE *(please circle what applies to you)*	
Current Pain score:	**0 1 2 3 4 5 6 7 8 9 10**
Pain score at worst:	**0 1 2 3 4 5 6 7 8 9 10**
Pain score at best:	**0 1 2 3 4 5 6 7 8 9 10**
Average pain score:	**0 1 2 3 4 5 6 7 8 9 10**

History of Present Illness:

When and how did your pain start?

_____

What makes your pain better?

_____

What makes your pain worse?

_____

Since you were last seen, has your pain: [ ] Increased [ ] Decreased [ ] Remained the same

What best describes your pain: [ ] Constant [ ] Intermittent

When is your pain worst: [ ] Morning [ ] Daytime [ ] Evening [ ] Night

In the past 3 months, have you developed any of the following *(Circle all that apply)*

Balance Problem Groin numbness Difficulty walking New weakness

Bowel Incontinence Bladder Incontinence New numbness

Any Updates to your Allergies/Medical/Surgical/Psychiatric History since your last visit?

Review of Systems: ***(Please circle all that apply to you)***			
Constitution Fever/chills Weight loss Malaise/fatigue Night sweats Weakness Swollen lymph nodes	**Eyes** Blurred/changes to vision Light sensitivity Eye pain Eye discharge Dry eyes	**Gastrointestinal** Heartburn Nausea/Vomiting Abdominal pain Diarrhea Constipation Incontinence of stool	**Hematology** Easy bruising Easy bleeding Blood clots
Skin Rash Itching Hair loss Fingers turn white with cold	**Cardiovascular** Chest pain Palpitations Difficulty breathing when lying flat Ankle/leg swelling	**Genitourinary** Painful urination Blood urine Flank pain Incontinence of urine	**Neurological** Dizziness Lightheadedness Headaches Tingling Tremor Sensory change Seizures
Ears/Nose/Throat Hearing loss Ear pain Sinus pain Sore throat Swollen lymph nodes Dry mouth Nose bleeds	**Respiratory** Cough/cold Sputum production Shortness of breath Wheezing	**Musculoskeletal** Muscle pains Neck pain Back pain Joint pain Recent falls Loss of height	**Psychiatric** Depression Suicidal thoughts Hallucinations Anxiety Difficulty sleeping Memory loss

Mark "X" on the picture where you are having discomfort.

If your pain radiates, please indicate with a line.

Please circle the best description of your pain.

Aching Stiffness Please describe your pain if not listed:

Burning Throbbing

Cramps Tingling

Dull Pins & Needles

Numbness Pounding

Sharp Cold

Shooting Heaviness