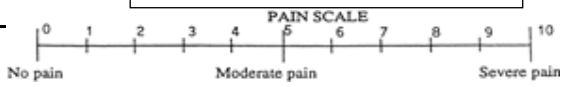
Advanced Interventional Pain & Sports Medicine Center

Follow-up

Height_____ Weight_____

1. **Name_____ Date_____**
2. **Chief complaint _____**
3. **Pain intensity** (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)



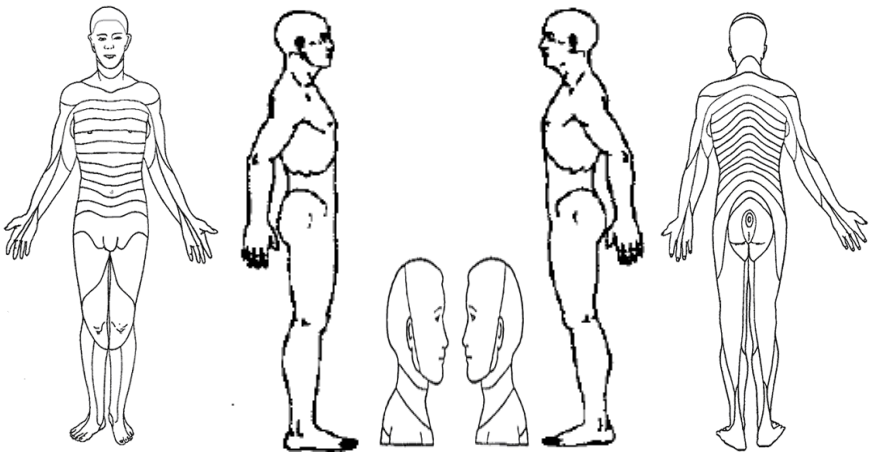
4. **Since last clinical visit the pain has:** decreased/increased/unchanged
5. **Date of last clinical visit_____ Date of last injection_____**
6. **Has your function improved_____** Yes/No **Has your your daily activities improved since last visit__** Yes/No
7. **How often is your pain present** Occasional Frequent Constant 24 hours, 7 days __/week __/month
8. **Is the pain** Aching Burning Stabbing Pressure Throbbing Deep Cramping Other_____
9. Please ***circle only one choice*** given below:

• I have only back pain	• I have only neck pain
• I have only leg pain	• I have only arm pain
• Back pain is more than leg pain	• Neck pain is more than arm pain
• Leg pain is more than back pain	• Arm pain is more than neck pain
• Back pain is equal to leg pain	• Arm pain is equal to neck pain

Do you have any?
Tingling Yes No Where_____
Numbness Yes No Where_____
Weakness Yes No Where _____

10. **Any bowel or bladder problems:** Yes/No **Any Fever/Infection**: Yes/No
11. **What worsens your pain:** Sitting standing walking bending driving lying on back Lying on stomach lying on the side sitting-to-standing coughing
12. **What decreases your pain:** Sitting standing walking bending lying on back Lying on stomach lying on the side Heat Ice medication
13. **Any change in medications since last visit?_____**
14. **Current Medications**:(List all medications)_____
15. **Any reduction or increase in pain medication? _____**
16. **Medical Problems:** Diabetes Hypertension Stroke Thyroid Heart Kidney Seizures Bleeding Liver Circulation HIV Reflux Pacemaker Defibrillator Asthma Hepatitis Murmur High cholesterol Ulcer COPD
17. Please **circle** if you have any of the following medical problems

General : *weight change, fevers fatigue*
Eyes: *glasses or contacts*
E.N.T.: *hearing aid, dental, trouble swallowing*
Cardiovascular *chest pain, blood clots, swelling*
Respiratory : *wheezing, shortness of breath*
Gastrointestinal: *ulcers, heartburn, bleeding*
Genitourinary: *infections, night time urination*
Musculoskeletal: *arthritis, gout, osteoporosis*
Integument: *breast lumps, mass, rash*
Neurologic: *fainting, seizures, stroke,*
Psychological: *depression, anxious*
Endocrine: *spontaneous temp. changes*
Hem/lymp: *anemia, bleeding problems*
Immunology: *HIV, Lupus*



Indicate the location of your pain with the following letters

Aching AA Stabbing SSS Burning BB Numbness NN Tingling TT
Pressure PP Other OO Cramping CC

Smoking Yes/No **How much_____**
Smoking is injurious to your health

18. **Any new medical problems since last clinical visit_____**
19. **Date of:** Flu shot_____ pneumonia shot_____ Mammogram_____ DEXA scan_____ Colonoscopy_____
20. **Allergies:_____** Location_____ Severity_____ Reaction_____
21. **Do you exercise?** Yes/No Walk Bicycle Treadmill_____ How many times a week?_____ For how long_____
22. **Do you know what your body mass index (BMI-please see below) is?** Yes/No *Increased weight increases load on your joints*
23. **Work Status** Full time Part time Restrictions Not working

To be completed by the physician

24. Physical Examination: Flex, Extension. Rotation
25. Radiology reports: MRI X-rays: Films Report
26. Diagnosis
27. Treatment Plan: Medication Injection Booklet PT

BMI Categories:
Underweight = <18.5
Normal weight = 18.5 to 24.9
Overweight = 25 to 29.9
Obesity = BMI of 30 or greater

For Office use
Booklet Surgery center Ultrasound EMG Injection at office Follow up