Flower Mound INTERVENTIONAL PAIN PHYSICIANS & ANESTHESIA SERVICES

FOLLOW UP QUESTIONNAIRE. Please answer all questions.

Where is your pain located?

How severe is your pain? (0 is no pain, 10 is worst pain) *Right now:* ____ *Average:* ____

How often do you have pain? Constantly Intermittently Infrequently Rarely

What is the pain like?

Achy *Sore* *Cramping* *Dull* *Throbbing*

Numb *Stabbing* *Pressure* *Sharp* *Shooting*

Pins/needles *Hot/burning* *Tingling* *Other* ______________________

Does your pain radiate or shoot to another location? NO

Left Head *Right head* *Trunk* *Other*__________________

Left Arm *Right arm* *Flank*

Left Leg *Right leg* *Groin*

What makes your pain worse? NOTHING

Bending *Sitting a long time* *Going up stairs* *Turning left*

Lifting *Standing a* long time *Going down stairs* *Turning right*

Movement *Standing straight up* *Increased activity* *Walking*

*Other*____

What makes your pain better? NOTHING

Medications *Massage* *Heat* *Walking* *Other:*________________________

Injections *Exercise* *Cold* *Manipulation*

Physical therapy *Rest* *Sitting* *Standing* *Lying flat*

Are you having any of these associated symptoms? NONE

Muscle Cramps *Poor Sleep*

Weakness *Feeling sad*

Numbness *Feeling frustrated*

Loss of bowel/bladder control

What is your goal for pain control? ____

Do you feel your condition is: *Improved* *Well-controlled* *Resolving* *Resolved*

Inadequately controlled *Worsening* *Unchanged*

Do you exercise and stretch? Never Occasionally Weekly 2-3 times a week Daily

Did you have a procedure at your last visit? YES NO

What procedure did you have? ____

What was your pain score before the procedure (0-10)? ________________

What was your pain score immediately after? ________________

How long did the pain relief last for? ____

Did you like the results of the procedure? YES NO

Any problems from the procedure? Redness Bleeding Bruising Weakness Numbness

Increased pain at injection site Other: ______________________

Would you go through the procedure again? YES NO

List the medications we are prescribing to you:

NAME OF MEDICATION	DOSE	Is it helpful?
____________________	____________________	YES NO
____________________	____________________	YES NO
____________________	____________________	YES NO
____________________	____________________	YES NO
____________________	____________________	YES NO

How much pain relief are you getting from the medications? ______________ (10%, 50% etc)

Are you seeing any improvements in your daily activities? YES NO

Are you having any of the following side effects?

Sleepiness *Disorientation* *Nausea* *GI Upset* *Rash* *Swelling*

Other ____

What has helped most with your pain? ____

Are you satisfied with your current level of pain control? YES NO

Please list any new allergies to medicines: ____

Any new medical conditions, medications, or surgeries?

****** SYMPTOMS REVIEW (Do you have any of these?)***

Constitutional:	fever	weight gain	weight loss	
Ears:	ear discharge	dizziness	earaches	
Head/Neck/Eyes:	visual changes	headaches	neck pain	pain in eyes
Nose/Throat:	nosebleeds	hoarseness	swallowing difficulty	
Cardiovascular:	chest pain irregular heart beat	leg swelling palpitations	poor circulation high blood pressure	blood clots
Respiratory:	coughing	wheezing	asthma	
Gastrointestinal:	heartburn stomach ulcer	nausea/vomiting diarrhea	painful bowel movement constipation	
Musculoskeletal:	muscle cramps stiffness	muscle twitches cold-weather pain	arthritis	swollen joints
Skin:	rash	shingles	itching	
Neurological:	weakness	numbness	tremors	poor coordination
Psychiatric:	depression	anxiety	mood swings	irritability
Hematologic:	easy bruising	anemia		
Endocrine:	excessive thirst	excessive urination	heat/cold intolerance	
Urinary:	painful urination	loss bladder control	blood in urine	kidney stones
Men only:	prostate trouble	erectile dysfunction		
Women only:	irregular periods	menstrual cramps	vaginal discharge	menopausal

Let us know if you would like a TENS unit or brace for the back, knee, or wrist.

Is there anything else you would like to discuss?