FOLLOW-UP EVALUATION

(Physicians- Dictate Template Type)

USE PATIENT PLATE

University of California, Davis
Medical Center
Sacramento, California
UCD Pain Management Center
Follow-up Visit Worksheet

Requesting Physician _____

Primary Care Physician (if not the same) _____

Patient Information

_____ Age ____ Sex: M ☐F☐
Last Name First M.I.

ABOUT YOUR PAIN (Chief Complaint)

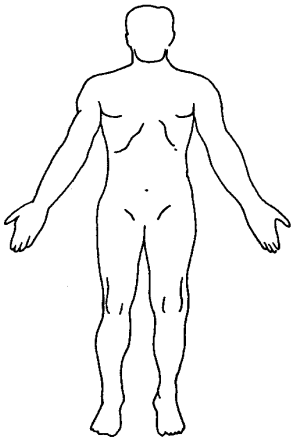
What is the main problem for which you are seeking treatment at the Pain Management Center?

_____

_____

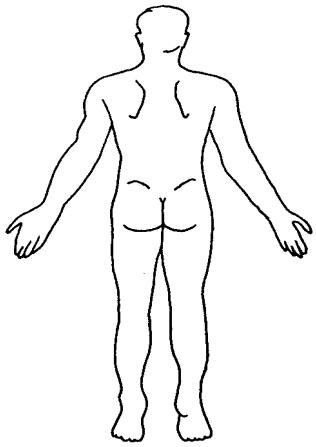
PAIN LOCATION

Right



Front

Left



Back

Right

Please mark the location(s) of your pain on the diagrams above with an "X." If whole areas are painful, please shade in the painful area.

ONSET OF PAIN and DURATION

When did your current pain start? _____

_____

Briefly describe how your current pain started? _____

_____

_____

FOLLOW-UP EVALUATION

TIMING OF PAIN

How often do you have your pain (please check one)?

☐ Constantly (100% of the time)
☐ Frequently (75% of the time)
☐ Intermittently (50% of the time)
☐ Occasionally (25% of the time)

PAIN QUALITY

How would you describe the pain (choose as many adjectives as are applicable)

☐burning	☐sharp	☐cutting	☐throbbing
☐cramping	☐numbness	☐dull, aching	☐pressure
☐pins and needles	☐shooting	☐electric-like	☐other

RATE YOUR PAIN INTENSITY

Please circle the one number that best describes your pain right now.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain Imaginable

Please circle the one number that best describes your pain on average over the last week.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain Imaginable

Percent overall improvement since coming to the UCD Pain Management Center _____ %

In the past week, how much **RELIEF** have your current pain treatments or medications provided?

Please circle the one percentage that best describes how much.

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

No Relief — Complete Relief

CURRENT MEDICATIONS: Patients will be a given current medication sheet to fill out or update. If you have not received a current medication sheet, please request one at the front desk of the clinic

STOPPED MEDICATIONS: (List medications that have stopped since your last visit and state the reason for stopping)

1
2
3

Past, Family, and Social History:

List activities (chores, exercise, walking longer distance, shopping, housework, etc.) you **CAN DO NOW** that you couldn't do before being referred to the pain clinic.
Write **'Nothing New'** if you cannot do anything more since being referred to the pain clinic.
List Activities:

Are you taking opioid medications? (morphine, Oxycontin, Vicodin, Norco, Percocet, etc.) No☐ Yes☐
If so, do these medications increase your level of function? No☐ Yes☐

List Activities that have increased?_____

FOLLOW-UP EVALUATION

How many blocks can you walk before having to stop secondary to pain?_____blocks
How long can you sit before you have to stand?_____minutes_____hours
How long can you stand before you have to sit?_____minutes_____hours
Since your last pain clinic visit, your activity level and ability to perform physical tasks has:
Increased☐ Unchanged☐ Decreased☐

Are you currently smoking or using tobacco products Yes☐ No☐

Review of Systems

Please check any of the following signs or symptoms that are currently experiencing.	YES		Office Use Only
fever or chills?	☐		Constitutional
unplanned weight loss?	☐		
double or blurred vision?	☐		Eyes
hearing loss?	☐		ENT
difficulty swallowing?	☐		
bleeding gums?	☐		Hematologic/Lymph
low platelet count?	☐		
heat intolerance?	☐		Endocrine
cold intolerance?	☐		
thyroid problems?	☐		
skin rash?	☐		Integumentary
shortness of breath?	☐		Resp
wheezing?	☐		
palpitations (awareness of fast heart)?	☐		Cor
chest pain?	☐		
constipation?	☐		GI
abdominal pain?	☐		
nausea?	☐		
vomiting?	☐		
diarrhea?	☐		
sexual dysfunction?	☐		GU
urinary retention or difficulty urinating?	☐		
back pain?	☐		Musculoskeletal
neck pain?	☐		
joint pain (knee, elbow, hip etc.)?	☐		
muscle pain?	☐		
loss of consciousness or blackouts?	☐		Neuro
memory loss?	☐		
muscle weakness?	☐		
seizures?	☐		
trouble walking?	☐		
dizziness?	☐		
drowsiness?	☐		
excessive fatigue?	☐		
difficulty falling or remaining asleep?	☐		Behav
loss of interest in hobbies or other activities?	☐		
difficulty concentrating?	☐		
feelings of guilt?	☐		
feeling depressed?	☐		

PRIOR INJECTIONS OR PROCEDURES

Name of procedure performed on your last visit _____None ☐
If yes, did you notice any relief? No ☐ Yes ☐
If yes, what percent relief did you notice?_____ % For how long? _____
Did you have any side effects from your last procedure? No ☐ Yes ☐
What was the side effect?_____